

FILED FEB 18 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007947  
State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1306**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>4 hrs</b>	c. CITY OR TOWN <b>Clayton, 2444<sup>th</sup> St</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Children's Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) <b>Michael</b> c. (Last) <b>Webb</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 2, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Mug. 26, 1950</b>
9. AGE (In years last birthday) <b>7yr</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Robert Myrl Webb</b>	
13b. MOTHER'S MAIDEN NAME <b>Rosa Frame</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Jane Henrichsen</b> ADDRESS <b>500 S. Kingshighway</b>

18. CAUSE OF DEATH (Enter only the cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>APLASTIC ANEMIA &amp; SEPSIS</b>		II. ANTECEDENT CAUSES <b>CARDIO-VASCULAR FAILURE</b>		
* This does not mean the mode of dying, such as heart failure, apnea, etc. It means the disease, injury or complication which caused death.		DUE TO (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>		
		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-2**, 19**58**, to **2-2**, 19**58**, that I last saw the deceased alive on **2-2**, 19**58**, and that death occurred at **7:50pm**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. K. Middekamp</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>500 S. Kingshighway</b>	23c. DATE SIGNED <b>2/2/58</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2/4/58</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Mausoleum</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Stock Mortuary</b> ADDRESS <b>889 S. Brentwood</b>	
DATE REC'D BY LOCAL REG. <b>FEB 4 1958</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Clayton.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Paul A. Wachter*

Licensed Embalmer No. *4287*

P. O. Address *St. Paul, Minn.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.