

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020264
STATE FILE NUMBER
1931

FILED MAY 16 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 27 Homer G. Phillips		Length of stay in lb 0		d. STREET ADDRESS 2279 1101 N. 18th	
3. NAME OF DECEASED (Type or print) Calvin Webb			4. DATE OF DEATH Month Day Year 5 6 58		
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-58	9. AGE (In years last birthday) 2 Months 11 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Lenard Webb		13b. MOTHER'S MAIDEN NAME Rosie Lee Nelson		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Rosie Lee Webb 1101 N. 18th St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cor tribraculare, distorsion of great vessels</i> 754.7 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Bronchopneumonia</i>					INTERVAL BETWEEN ONSET AND DEATH undet.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 4-1-58 to 5-6-58 and last saw him alive on 5-6-58 Death occurred at 2:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Paul White, M.D.</i>			22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 5-7-58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 5-16-58		23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON CEMETERY	
				23d. LOCATION (City, town, or county) (State) ST. LOUIS CO., MISSOURI	
24. FUNERAL DIRECTOR <i>P. Watkins 2700 Thomas</i>			25. DATE RECD. BY LOCAL REG. MAY 9 '58		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> J.C.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

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

Student

Signature of Student Embalmer

Signed

Leroy W. Sannister

Licensed Embalmer No. 4523

P. O. Address 4251 Washu

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.