

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. Louis		c. CITY OR TOWN ST. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 948² HICKORY	

3. NAME OF DECEASED (Type or print) First JAMES Middle M. Last Webbe			4. DATE OF DEATH Month SEPT Day 4 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1920	9. AGE (last birthday) 39
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mo. STATE SENATOR		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. Louis Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME MICHAEL Wobbe		13b. MOTHER'S MAIDEN NAME Louise Leisure		14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		16. SOCIAL SECURITY NO.	17. INFORMANT JOHN Webbe	Address 948² HICKORY
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renue failure				INTERVAL BETWEEN ONSET AND DEATH 4 years
DUE TO (b) arterial hypertension				5¹ years.
DUE TO (c) hypertensive heart disease				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443 x				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 Sept 1951 to Sept 1960 and last saw ^{her} (him) live on Sept 3 1960 Death occurred at Sept 3 1960 4A on the date stated above, and to the best of my knowledge, from the causes stated.				

21a. SIGNATURE (Degree or title) Harold Freedman MD		21b. ADDRESS 607 No Grand Bldg		21c. DATE SIGNED SEP 8 1960
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT 7, 1960	23c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL CH.	23d. LOCATION (City, town, or county) ST. Louis Mo	(State)
24. FUNERAL DIRECTOR Thomas Katis		ADDRESS 2906 Grannis	25. DATE RECD. BY LOCAL REG. SEP 6 1960	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

12³⁰ - 5⁰⁰
R1625

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleanora Poire

Licensed Embalmer No. 340

P. O. Address 2906 Grand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.