

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis, Missouri**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **City Hospital, #1**  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution **3 Mos., 19 Days**  
(Specify whether \_\_\_\_\_)  
In this community **3 Years**  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis, Mo** **23**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1614A So. 14th St.,**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Leroy Webb** **167**  
3. (b) If veteran, name war **World War**  
3. (c) Social Security No. **702-16-5996**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **July** day **21**,  
year **1940** hour **3:25** minute **A.** M.

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Nell Webb**  
6. (c) Age of husband or wife if alive **27** years  
7. Birth date of deceased **May 8 1893**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 2, 1940** to **July 21, 1940**;  
that I last saw him alive on **July 21, 1940**;  
and that death occurred on the date and hour stated above.

8. AGE: Years **47** Months **2** Days **13** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death  
**Pulmonary Thrombosis**  
**Lung Abscess**  
Due to **Pulmonary tuberculosis**  
Other conditions (include pregnancy within 3 months of death)

9. Birthplace **Lompoc Calif** (City, town, or county) (State or foreign country)  
10. Usual occupation **Bridge Worker**  
11. Industry or business \_\_\_\_\_

PHYSICIAN  
Major findings:  
Of operations **23**  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **Donald Webb** **4**  
13. Birthplace **Scotland** (City, town, or county) (State or foreign country)  
14. Maiden name **Bertha Lyman** **9**  
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Nell Webb**  
(b) Address **1614A So. 14th St.,**  
17. (a) **Burial** (b) Date thereof **7-24-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Mt. Hope Cemetery**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director **A. W. McLaughlin**  
(b) Address **JUL 22 1940 Lafayette Avenue**  
19. (a) \_\_\_\_\_ (b) **J. F. Brudeck**  
(Date received local registrar) (Registrar's signature)

While at work (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature **J. F. Brudeck** (M. D. or other)  
Address **1515 Lafayette,** Date signed **7/22/40**

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

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**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*L.R. Cooper*

Licensed Embalmer No. ....

*3633*

P. O. Address.....

*2317 Lafayette*

**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 this body is not embalmed, fact should be so stated above.**