

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS. NOV 3 1960

318

Primary Registration District No. 1003

Registrar's No. 10291

-60-040349

STATE FILE NUMBER

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4365 St. Ferdinand</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Enoch</b> Middle <b>Webb</b> Last <b>Webb</b>				4. DATE OF DEATH Month <b>10</b> Day <b>21</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-30-11 48</b>		9. AGE (last birthday) <b>48</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Union Electric Co.</b>		11. BIRTHPLACE (City and state or country) <b>Noxubee Miss.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Enoch Webb</b>			13b. MOTHER'S MAIDEN NAME <b>Lizz ie Allen</b>			14. NAME OF HUSBAND OR WIFE <b>Josie Webb</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES War 21</b>		16. SOCIAL SECURITY NO. <b>426-14-4311</b>		17. INFORMANT <b>Josie Webb</b>		Address <b>4365 St. Fredinand</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Millard-Gubner Syndrome due to</b> DUE TO (b) <b>Brain Tumor (Malignant)</b> DUE TO (c) <b>193.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Left Ipsilateral Faciale Paralysis, Right Right / Contralateral Hemiplegia</b>						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 _____ Month, Day, Year _____ a.m. _____ p.m. _____							
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 <b>10-16-60</b> to <b>10-21-60</b> and last saw <del>her</del> him alive on <b>10-21-60</b> Death occurred at <b>9:10</b> a. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Edward B. ...</i> (Degree or title)				22b. ADDRESS <b>2601 N. Whittier St.</b>		22c. DATE SIGNED <b>10-22-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipping</b>		23b. DATE <b>10-26-60</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Amory, Miss.</b>		(State)
24. FUNERAL DIRECTOR <b>Atkins Bros. 3614 Finney</b>			25. DATE RECD. BY LOCAL REG. <b>OCT 24 1960</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith. M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

*John K. Cunningham*

Licensed Embalmer No. 4476

P. O. Address 2405 Mc

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.