

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044521

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 XC-1184 958 SL 28891 Primary Registration District No. 1003 Registrar's No. 11479 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 21 1962

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N. Grand, St. Louis, Mo.</u>		Length of stay in 1b <u>2 days</u>	c. CITY OR TOWN <u>E. St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2803 Summitt</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle (Last) <u>ADEN D. (de Beau) LEBO</u>		4. DATE OF DEATH Month Day Year <u>November 28 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/88</u>
9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Carrier Mills, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Douglas Lebo</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Vinson</u>		14. NAME OF HUSBAND OR WIFE <u>Juliet Lebo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>WA-1</u>	17. INFORMANT Address <u>Juliet Lebo (Wife), Same add. as 2.</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-6 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <u>163x</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 <u>11/26/62</u> to <u>11/28/62</u> and last saw him alive on <u>11/28/62</u> Death occurred at <u>3:40 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Print or type name) <u>Andrew W. Mc Roberts</u>		22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>11/28/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-1-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem</u>	23d. LOCATION (City, town, or county) (State) <u>Carrier Mills Ill.</u>
24. FUNERAL DIRECTOR <u>ROBINS</u> ADDRESS <u>417 N. 8th St. East St. Louis, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 29 1962</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

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 Frank Travoff

Licensed Embalmer No. 4356

P. O. Address St. Louis Mo.

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.