

No. 2
-10-39
7-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27574**
3207
Registrar's No. _____

REG SEP 5 1940 399
Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St Lukes Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 weeks** (Specify whether
In this community **35 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **109 S Oakley** (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME **Mrs. Hattie Webb** **1071**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **Nons**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Louis H. Webb** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug. 14, 1857**
(Month) (Day) (Year)

8. AGE: Years **82** Months **11** Days **27** If less than one day _____ hr. _____ min.

9. Birthplace **Georgia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Homemaker**

11. Industry or business **At Home**

12. Name **Robert S. Patton**

18. Birthplace **N.C.**
(City, town, or county) (State or foreign country)

14. Maiden name **Bowen**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Chas. H. Webb**

(b) Address **109 S Oakley, K.C., Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 13-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove, Mo.**

18. (a) Signature of funeral director **C.H. Blackman & Son, Inc.**
(b) Address **K.C., Mo.**

19. (a) **Aug. 13, 1940** (b) **M.M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **11th**
year **1940** hour **6** minute **A** M.

21. I hereby certify that I attended the deceased from **7/11/40**, 19____, to **8-11-40**, 19____;
that I last saw h. **ER** alive on **8-11-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized Atherosclerosis**
Senility Duration _____

Due to _____ **97**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **No Operation**
Of operations _____

Of autopsy **No Autopsy**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? **361**

23. Signature **J. R. ...** (M. D. or other) **M.D.**
While at work? (Specify type of place) (e) Means of injury _____

Address **311 Ogden Bldg** Date signed **8/12/40**

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

MOTHER FATHER

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 _____

Licensed Embalmer No. 8639

P. O. Address K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.