No. 2
-13-40
17-39
X23159

FILED FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1232

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 192

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3400 Olive 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... In this community: 45 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 4
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No.: 4616 Tracy 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Rosa W. Webb
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: F
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: George W. Webb
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: 5 (Month) 21 (Day) 1868 (Year)

8. AGE: Years 72 | Months 7 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace: Coffeyville (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Housekeeper
11. Industry or business: 9
MOTHER FATHER
12. Name: No Record
13. Birthplace: ..... (City, town, or county) ..... (State or foreign country)
14. Maiden name: Elizabeth Lyles
15. Birthplace: ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant: Mrs. Garth S. Webb
(b) Address: 3400 Olive
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 13-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Washington
18. (a) Signature of funeral director: Bentley Mortuary
(b) Address: 5811 Troost Avenue
19. (a) Jan 13 1941 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11 year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from Dec 17-1940, 19..., to Jan 11, 1941, that I last saw her alive on Jan 9, 1941, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Pneumonia	1 wk
Due to: Senility	
Due to: Chronic Interstitial Nephritis	Dont Know
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: None | 13 | 1x
Of 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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: J. E. Ball (M. D. or other)
Address: 1102 E 47 Date signed 1/13/41

(Licensed Embalmer's Statement on Reverse Side)

Dr. James A. Ball
Troost Center

Wa. 1993

110 2 3 4 7 Dw

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 Guy Buffington

Licensed Embalmer No. 2756

P. O. Address.....

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

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

S. No. 2B
M—8-21-41
I X29288

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

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1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Rose M. Webb
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: 5 (Month) 21 (Day) 1868 (Year)

8. AGE: Years 72 | Months 7 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....

MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
14. Maiden name .....
15. Birthplace: no record (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) Jan 13-1941 (Date received local registrar) (b) M M Crouse (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day ..... year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw him alive on ..... 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of 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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

S-1232