

STANDARD CERTIFICATE OF DEATH

State File No. **13548**  
Registrar's No. **1529**

Registration District No. **399**

Primary Registration District No. **1002**

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:  
**K.C. General Hospital No. 1** **0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 hrs.**  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**  
(c) City or town **Kansas City** **3**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2700 E. 15th St.** **8**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **20th**  
year **1941** hour **12:00** M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from  
**3-20-41** 19\_\_\_\_ to **3-20-41** 19\_\_\_\_;  
that I last saw him alive on **3-20-41** 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Prematurity**  
Duration  
**12 1/2**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **None**  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_  
23. Signature **Drury R. Thorn** (M.D. or other) **0**  
Address **Med. Dir. K.C. Gen. Hospital** Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME **Webb infant**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **H. 0** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **S. 0**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **March 20th 1941**  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day **7 hrs.** min. \_\_\_\_\_

9. Birthplace **K.C. Mo. 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Clarence Clifford Webb**  
13. Birthplace **Iowa /** (City, town, or county) (State or foreign country)  
14. Maiden name **Lorraine Mary Kurling**  
15. Birthplace **Iowa /** (City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**  
(b) Address **K.C. Gen Hosp., K.C. Mo.**  
17. (a) **Burial** (b) Date thereof **4-17-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Municipal Cem. Leeds Mo.**  
18. (a) Signature of funeral director **W. A. Lohmeyer**  
(b) Address **City mortician**  
19. (a) **April 16, 1941** (b) **Dr. M. M. Crowe**  
(Date received local registrar) (Registrar's signature)

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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**