

No. 2
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DEPARTMENT OF COMMERCE
Missouri State Board of Health
FILED OCT 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31872**

Registration District No. **431**

Primary Registration District No. **302-33**

Registrar's No. **116**

1. PLACE OF DEATH

(a) County **Johnson**
(b) City or town **Warrensburg**
(c) Name of hospital or institution: **Warrensburg Clinic**
(d) Length of stay: In hospital or institution **4 days**
In this community **4 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**
(c) City or town **Warrensburg**
(d) Street No. **200 Tyler St**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Dora May Webb**

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

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

6. (b) Name of husband or wife **Claver J. Webb** 6. (c) Age of husband or wife if alive **1864** years

7. Birth date of deceased **May-1-1864**

8. AGE:	Years	Months	Days	If less than one day
	77	4	16	

9. Birthplace **Diskinwa Ill.**

10. Usual occupation **Housekeeper**

11. Industry or business

12. Name **Eliaz J. Benson**

13. Birthplace **Douglas Mass.**

14. Maiden name **Mary Beach**

15. Birthplace **Aberdgon Pa.**

16. (a) Informant **Frank J. Webb**

17. (a) **Burial** (b) Date thereof **Sep. 20-1941**

18. (a) Signature of funeral director **Sweeney Phillips**

19. (a) **Sep-18-1941** (b) **Lola M. Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sep** day **17** year **1941** hour **13:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **Sep 14** 1941 to **Sep 17** 1941 that I last saw him alive on **Sep 17** 1941 and that death occurred on the date and hour stated above.

Immediate cause of death **Left cerebral hemorrhage** Duration **1 da**

Due to **hypertensive cardiac-vascular disease**

Due to

Other conditions **730**

Major findings: Of operations **730** 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?

23. Signature **CS Johnson MD** (M. D. or other) Address **Warrensburg Mo** Date signed **Sep 18 1941**

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

MOTHER FATHER

OCT 7 1941

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.....

R. A. Phillips.
working under my personal supervision.

....., Registered Apprentice No.

Signed *R. A. Phillips.*

Licensed Embalmer No. *2320.*

P. O. Address *Warrensburg.*

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.