

REG 10 AUG 10 1942  
Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 173

48  
4  
4

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Independence Sanitarium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days  
(Specify whether years, months or days)

In this community 6 days

3. (a) PRINT FULL NAME Keith Webb

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June - 27 - 42  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Independence Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name Bruce Webb

13. Birthplace Oak Grove Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Ethel Moore

15. Birthplace Oak Grove Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Bruce Webb

(b) Address Oak Grove Mo

17. (a) Burial (b) Date thereof 7-3-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mo

18. (a) Signature of funeral director W. B. Webb - son

(b) Address Oak Grove Mo

19. (a) 7-3-1942 (b) James W. Ross  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Lapeer

(c) City or town Rural 2 1/2 miles S.E. Oak Grove  
(If outside city or town limits, write "RURAL")

(d) Street No. Snobar Township  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4  
year 1942 hour \_\_\_\_\_ minute 10:30 M.

21. I hereby certify that I attended the deceased from June 28 1942 to July 4 - 1942  
that I last saw him alive on July 4 - 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Transposition of the Aorta

Due to Development in utero

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Transposition of the aorta left side  
Of autopsy atelectatic pneumonia in left lung

Duration born that way

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)

(e) Means of injury \_\_\_\_\_

23. Signature R. H. Allen (M. D. or other) M.D.  
Address Independence, Mo. Date signed 7-4-42

---

---

**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 RB Webb

Licensed Embalmer No. 2347

P. O. Address Blair Springs Md

**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.**