

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of town or city)  
 (c) Name of hospital or institution: Home 14611 East 10th  
(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 37 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4611 East 10th, St.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Jeanette Belle Webb

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

4. Sex Fe. 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Webb 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Sept. 19th, 1867  
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 4 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business Own home

MOTHER FATHER { 12. Name David P. Tomlison  
 13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Martha Nichols  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Anna Ross  
 (b) Address 6411 East 10th, St.

17. (a) Burial (b) Date thereof 1/26/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt. Moriah Cem

18. (a) Signature of funeral director Farp Funeral Home  
 (b) Address Kansas City, Mo

19. (a) Jan 24 1944 (b) J. Brown  
(Date received by registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 23rd, year 1944 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from Nov 15 1943 to Jan 23 1944, that I last saw her alive on Jan 21 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion  
Chronic myocarditis  
arteriosclerosis  
 Due to \_\_\_\_\_  
 Due to Senility

Duration  
2 hrs  
2 hrs  
2 hrs

Other conditions: None  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy no 93d

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) no  
 (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 J. Brown (M. D. or other) O. 2nd  
 Address 800 Elmwood Date signed 1-24-44

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

105 Wood  
10-19-46

**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 John B. Camp  
Licensed Embalmer No. 29153  
P. O. Address 112 No

**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.**