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17-39  
X35697

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

FILED MAY 28 1944

State File No. ....

4523

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. ....

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Pacific Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 24  
(c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 320 N. Main Street  
(If rural, give location) N.R.  
(e) Citizen of foreign country? / (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Adolphus Francis Webb

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

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

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

7. Birth date of deceased June 18, 1858  
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired section foreman

11. Industry or business Mo. Pac. R. R. Co.

MOTHER FATHER { 12. Name ?  
13. Birthplace ? (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace ? (City, town, or county) (State or foreign country)

16. (a) Informant L. H. Webb,

(b) Address Fontana, Cal.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/44  
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) MAY 16 1944 (Date received local registrar) J. F. B... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 yr. 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 24/44, 19... to 5/15/44, 19...; that I last saw him alive on 5/15/44, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Disease  
Pyelonephritis - non-  
infectious  
Prostatic Hypertrophy  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 133

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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 C. D. Drace, Jr. (M. D. or other) MD. Pacific Hospital Date signed 5/15/44

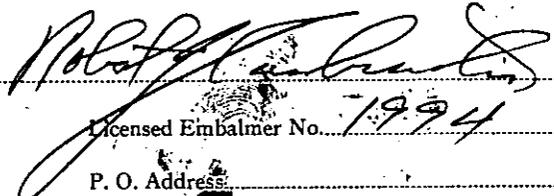
**STATEMENT BY LICENSED EMBALMER**

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. 7994

..... 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.**