. S. No. 2
OM-5-43
ev. 5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26645

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3518

1. PLACE OF DEATH:

(a) County Jackson 48
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
622 East 40th St.Apt.#7
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 622 East 40th St.Apt.#7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mrs. Katheryn Webber

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frank M. Webber

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 10, (Day) 1885 (Year)

8. AGE:

Years	Months	Days	If less than one day
60	5	11	hr. min.

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

10. Usual occupation At home

11. Industry or business

FATHER
12. Name James R. Wiley
13. Birthplace Iowa (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah P. Jackson
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Harold W. Webber
(b) Address Leavenworth Kas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thomas E. Quirk
(b) Address 4316 Troost Ave.

19. (a) 8-22-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21st year 1945 hour 12: minute 30 A. M.

21. I hereby certify that I attended the deceased from July 31, 1945, to Aug 21, 1945 that I last saw her alive on 7-21, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis — Duration 10 hrs

Due to

Due to 94a

Other conditions Secondary Anemia
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Harry L. Jones (M. D. ~~or other~~ M.D.
Address 1107 Bryant Bldg. Date signed 8-22-45

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas E. Quirk

Licensed Embalmer No. 3775

P. O. Address K. C. Mo

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.