

No. 17-39
X35637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12077**

FILED APR 24 1946

Registration District No. _____ Primary Registration District No. **3000** Registrar's No. **75**

1. PLACE OF DEATH:
 (a) County **Adair**
 (b) City or town **Kirksville**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **✓ 1**
 (If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution **80 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Adair**
 (c) City or town **Kirksville**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **507 W. Hickory**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Amy Webb**
3. (b) If veteran, name war **✓**
3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **February** **25**
 year **1946** hour **6:30** minute **P.** M.
21. I hereby certify that I attended the deceased from
5-26 19**44** to **2-25** 19**46**
 that I last saw her alive on **2-25** 19**46**
 and that death occurred on the date and hour stated above.

4. Sex **female** **5. Color or race** **white**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **J. D. Webb**
6. (c) Age of husband or wife if alive **6** years
7. Birth date of deceased **June 6, 1865**
 (Month) (Day) (Year)

Immediate cause of death: **Myocarditis with Myocardial degeneration.** Duration **3 wks.**
 Due to: **Cardio-vascular disease with asthma** **10 yrs.**
 Due to: _____

8. AGE: Years **80** Months **8** Days **20** If less than one day hr. min.
9. Birthplace **Mexico** **Mo. 0**
 (City, town, or county) (State or foreign country)
10. Usual occupation **Housekeeper**

Other conditions: _____ (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: _____
 Of autopsy: **938**

11. Industry or business _____
12. Name **J. H. Webb**
13. Birthplace **Pa. 1**
14. Maiden name **Mary Cooper**
15. Birthplace **Pa. 1**
16. (a) Informant **Tom Smith**
(b) Address **Kirksville, Mo.**
17. (a) Burial (b) Date thereof **3-3-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Highland Park**
18. (a) Signature of funeral director **Davis Funeral Home**
(b) Address **Kirksville, Mo.**
19. (a) 3-11-46 (b) **Kate Lambert**
 (Date received local registrar) (Registrar's signature)

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 **2**
23. Signature **Howard E. Gross** (M. D. or other) **P.O.**
Address **Kirksville, Mo.** Date signed **3-11-46**

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

10986

RECEIVED

District Health Officer No. 40

District File Number 4-46-817

Date Filed APR 22 1946

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..... *Bowden Beatty*

Licensed Embalmer No. 4379

P. O. Address Kirksville, 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.