

FILED OCT 28 1948
Registration District No. **155**

Primary Registration District No. **3127**

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

1. PLACE OF DEATH:

(a) County **Jasper**

(b) City or town **Webb City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
623 North Hall Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **63 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** **47**

(c) City or town **Webb City**
(If outside city or town limits, write "RURAL")

(d) Street No. **623 North Hall Street**
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME **Mattie Schurman**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **18**
year **1948** hour **11** minute **P** M.

4. Sex **F.** 5. Color or race **W.**

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

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive **23** years (Day) (Year)

7. Birth date of deceased **November 23, 1864**
(Month) (Day) (Year)

I hereby certify that I attended the deceased from **Mag 27**, 19**39** to **Oct 18**, 19**48**
that I last saw her alive on **Oct 18**, 19**48**
and that death occurred on the date and hour stated above.

8. AGE: Years **83** Months **10** Days **25** If less than one day
hr. min.

Immediate cause of death **Chronic Fibro myocarditis**

Due to.....

Due to.....

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

9. Birthplace **Kokomo Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

Underline the cause of which death should be charged statistically.

11. Industry or business.....

12. Name **Eleavor Littler**

13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Louiza T. Recon**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

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.....

Signature **Ray J. Starnord** (M.D. or other) **MD**

Address **Webb City Mo** Date signed **12/1/48**

16. (a) Informant **Ralph Keane (Son)**

(b) Address **Ponca City, Oklahoma**

17. (a) **burial** (Burial, cremation, or removal)

(b) Date thereof **10/21/48**
(Month) (Day) (Year)

(c) Place: burial or cremation **Webb City Cemetery**

18. (a) Signature of funeral director **Hedge Lewis**

(b) Address **Webb City, Missouri**

19. (a) **OCT 21, 1948** (Date received local registrar)

(b) **[Signature]** (Registrar's signature)

Sto.....

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

C. H. Helge

Licensed Embalmer No.

2859

P. O. Address

Webb City, 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.