

FILED OCT 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Busick 33618
State File No. _____
Registrar's No. 935

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 935		
1. PLACE OF DEATH a. COUNTY GREENE b. CITY OR TOWN SPRINGFIELD c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION 1933 N. DOUGLAS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE c. CITY OR TOWN SPRINGFIELD d. STREET ADDRESS 1933 N. DOUGLAS				
3. NAME OF DECEASED (Type or Print) a. (First) SHARON b. (Middle) ELAINE c. (Last) WEBB			4. DATE OF DEATH (Month) (Day) (Year) OCT 24 1949					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH MARCH 6, 1944		9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY INFANT		11. BIRTHPLACE (State or foreign country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME REV. BERT WEBB			13b. MOTHER'S MAIDEN NAME Charlotte Williamson		14. NAME OF HUSBAND OR WIFE SINGLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS REV. BERT WEBB SPEED				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sarcoma Both orbits, face jaw ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sarcoma (mixed type Rorich 4 yrs. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
19a. DATE OF OPERATION 12-29-45		19b. MAJOR FINDINGS OF OPERATION Mixed type sarcoma in orbit.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 12-11-1945, to 10-24, 1949, that I last saw the deceased alive on 10-24, 1949, and that death occurred at 4:05 A.M., from the causes and on the date stated above.								
23a. SIGNATURE Urban Busick (Degree or title)				23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 10-24-49		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Oct 25-49	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Mo.			
DATE REC'D BY LOCAL REG. 10-25-49		REGISTRAR'S SIGNATURE W.S. Handley, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Klingner & Co. Springfield			

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Max Rhodes

Signed.....

Student Embalmer

Licensed Embalmer No. _____

4071

P. O. Address _____

Springfield

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.