

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8886**
REGISTRAR'S NO. **1062**

BIRTH NO. **15873-51** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (If this place) Life		3718	
d. FULL NAME OF HOSPITAL OR INSTITUTION: General Hospital No. 1		d. STREET ADDRESS (If rural, give location) 903 Penn	

3. NAME OF DECEASED (Type or Print)	a. (First) Inf	b. (Middle)	c. (Last) Webb	4. DATE OF DEATH (Month) (Day) (Year) 2 21 51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2-20-51	9. AGE (In years last birthday) 1 1/2	IF UNDER 1 YEAR Days	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Ira Webb	13b. MOTHER'S MAIDEN NAME Freda Allen	14. NAME OF HUSBAND OR WIFE --
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Freda Webb	ADDRESS 903 Penn.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 76²⁵
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) - Prematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH Fetal endocarditis Pulmonary atelectasis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb. 20, 19 51** to **Feb. 21, 19 51**, that I last saw the deceased alive on **Feb. 21, 19 51**, and that death occurred at **6:17 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE D. Burns M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 2-23-51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-28-51	24c. NAME OF CEMETERY OR CREMATORY Leds Cemetery	24d. LOCATION (City, town, or county) (State) Leds Jackson MO
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DATE REC'D BY LOCAL REG. 3-9-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Schuyler	ADDRESS KC MO
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R. Hartwig

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.....

Not Embalmed

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed..... *Kenneth Lohmeyer*

Licensed Embalmer No. *3089*

P. O. Address *15 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.