

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36140**
4883

FILED OCT 28 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4883</u>			
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u>				b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>			c. LENGTH OF STAY (in this place) <u>45 YEARS</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RESEARCH HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>4305 GILLHAM ROAD</u>				<u>3668</u> <u>0</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>NELLIE</u>			b. (Middle) <u>C.</u>		c. (Last) <u>WEBB</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCTOBER 7 1953</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED 2</u>		8. DATE OF BIRTH <u>NOVEMBER 27, 1897</u>		9. AGE (In years last birthday) <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS, MISSOURI</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>FANNING</u>			13b. MOTHER'S MAIDEN NAME <u>LOUISE MOON</u>			14. NAME OF HUSBAND OR WIFE <u>WILLIAM B. WEBB</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. HELEN R. ROBERTS DETROIT, MICHIGAN</u>				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Colon with obstruction</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Arteriosclerotic Heart Disease;</u> Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						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) (Min.)		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 _____, 19 <u>42</u> , to <u>Oct. 7</u> , 19 <u>53</u> that I last saw the deceased alive on <u>Oct. 7</u> , 19 <u>53</u> , and that death occurred at <u>11:55 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Ipa C. Boyton</u> (Degree or title) <u>MD</u>						23b. ADDRESS <u>MD MD Arville Bldg.</u>		23c. DATE SIGNED <u>10-7-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT. 10, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAN CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>			
DATE REC'D BY LOCAL REG. <u>10-10-53</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>A. H. Newcomer Sons</u>		ADDRESS <u>1334 BRUSH CANY</u>		

WRITE PLAINLY—USING UNFADEING 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..

Student.....
Signature of Student Embalmer

Signed.....
Robert E. Heron

Licensed Embalmer No. *784*

P. O. Address *J. C. Moore*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**