

FILED JAN 21 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6005 State File No. 57

BIRTH NO. REG. DIST. NO. 293 PRIMARY REG. DIST. NO. 4436 Registrar's No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Ralls County 0870                              |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY Ralls |  |
| b. CITY (If outside corporate limits, write RURAL and give township) Hannibal |  | c. CITY (If outside corporate limits, write RURAL and give township) New London 0870                                       |  |
| c. LENGTH OF STAY (in this place) 3 mons                                      |  | d. STREET ADDRESS (If rural, give location)  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION                                       |  |  |  |

|  |  |                        |  |  |  |                             |  |  |  |                        |                                  |                       |                      |
|--|--|------------------------|--|--|--|-----------------------------|--|--|--|------------------------|----------------------------------|-----------------------|----------------------|
| 3. NAME OF DECEASED (Type or Print)  |  | a. (First) Rachel      |  | b. (Middle) Elizabeth  |  | c. (Last) Webb              |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>Jan 3 55            |  |                        |                                  |                       |                      |
| 5. SEX Female  |  | 6. COLOR OR RACE White |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married |  | 8. DATE OF BIRTH 11/25/1890 |  | 9. AGE (In years last birthday) 64                           |  | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days             | IF UNDER 1 MIN. Hours | IF UNDER 1 MIN. Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |                        |  | 10b. KIND OF BUSINESS OR INDUSTRY                              |  |                             |  | 11. BIRTHPLACE (State or foreign country) New Canton, Ill. / |  |                        | 12. CITIZEN OF WHAT COUNTRY? USA |                       |                      |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME Samuel Manker   |  | 13b. MOTHER'S MAIDEN NAME Isabelle Reynolds |  | 14. NAME OF HUSBAND OR WIFE William D. Webb                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.                     |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Wm. D. Webb New London, Mo. |  |

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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                                 |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs. |  |
| 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach   |  | DUPLICATE   |  |  |  |  |  |  |  |
| ANTECEDENT CAUSES   |  | DUE TO (b) generalized metastasis to liver and lungs. |  |  |  |  |  |  |  |
|   |  | DUE TO (c)  |  |  |  |  |  |  |  |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |   |  |  |  |  |  |  |  |

|  |  |  |  |   |  |      |  |  |  |
|--|--|--|--|---|--|------|--|--|--|
| 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) |  | 151X |  |  |  |
| 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 2/6/51, 19, to 1/3/55, 19, that I last saw the deceased alive on 9/11, 19 54, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. SIGNATURE (Degree or title) M. D. O         |  | 23b. ADDRESS Hannibal, Missouri               |  | 23c. DATE SIGNED 1/5/55  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial |  | 24b. DATE 1/5/55                              |  | 24c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park Ralls County, Missouri |  |
|  |  | 24d. LOCATION (City, town, or county) (State) |  |  |  |

|                                   |  |                                      |  |  |  |
|-----------------------------------|--|--------------------------------------|--|--|--|
| DATE REC'D BY LOCAL REG. 11-195-5 |  | REGISTRAR'S SIGNATURE Grace Coon 470 |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br>A.M. O'Donnell Hannibal, Mo. |  |
|-----------------------------------|--|--------------------------------------|--|--|--|

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed..... *H. M. O'Donnell*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3889

P. O. Address..... Hannibal, Missouri

**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.**