

FILED AUG 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25664**

BIRTH NO. _____ REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **3016** Registrar's No. **251**

1. PLACE OF DEATH a. COUNTY Cole		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cole	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jefferson City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jefferson City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 409 E. Capitol Ave.		d. STREET ADDRESS (If rural, give location) 409 E. Capitol Ave.	

3. NAME OF DECEASED (Type or Print) Nancy ?Cornilia Webb			4. DATE OF DEATH Aug. 18, 1955		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 7, 1879	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR 5 Months	IF UNDER 1 YEAR 11 Days	IF UNDER 1 MTH. 11 Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY OWN	11. BIRTHPLACE (City and State or Foreign Country) Versailles, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME David Deard	13b. MOTHER'S MAIDEN NAME Emile Beanland	14. NAME OF HUSBAND OR WIFE Jess Webb
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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. no	17. INFORMANT'S SIGNATURE OR NAME Mrs H.B. Sloan ADDRESS Jefferson City, Mol
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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		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocarditis		DUE TO (b) Arteriosclerotic Heart Disease		unknown
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)		unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4/200		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Aug 18, 1955**, to **Aug 18, 1955**, that I last saw the deceased alive on **Aug 18, 1955**, and that death occurred at **2p** m., from the causes and on the date stated above.

23a. SIGNATURE William C. Cox M.D. (Degree or title)	23b. ADDRESS 125 E High St Jefferson City Mo	23c. DATE SIGNED Aug 19 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 20, 1955	24c. NAME OF CEMETERY OR CREMATORY Greenfield Cemetery	24d. LOCATION (City, town, or county) (State) Greenfield Mo.
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DATE REC'D BY LOCAL REG. 19 Aug 1955	REGISTRAR'S SIGNATURE R.P. Davis MD MR	25. FUNERAL DIRECTOR'S SIGNATURE Udo Buscher ADDRESS Jefferson City Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 25 1956

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
Student Embalmer

Signed Victor Buecher

Licensed Embalmer No. 2701

P. O. Address Jefferson City

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.