

FILED AUG 30 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **25698**BIRTH NO. _____ REG. DIST. NO. **98** PRIMARY REG. DIST. NO. **4153** Registrar's No. **55-70**

1. PLACE OF DEATH a. COUNTY DADE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY DADE	
b. CITY (If outside corporate limits, write RURAL and give township): LOCKWOOD MO		c. LENGTH OF STAY (in this place) 4 DA	c. CITY OR TOWN LOCKWOOD MO
d. FULL NAME OF HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL		STREET ADDRESS (If rural, give location) 0290	

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) ALBERT c. (Last) WEBB			4. DATE OF DEATH (Month) (Day) (Year) AUG 20 1955		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 20 1870	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (City and State or Foreign Country) Oregon Co Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James Webb		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Bertha Webb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME C.A. Webb Lockwood M.	

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) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Arteriosclerosis		1 yr +	
		DUE TO (c) H500			
II. OTHER SIGNIFICANT CONDITIONS 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 **10-24**, 19**52**, to **8-20**, 19**55**, that I last saw the deceased alive on **8-20**, 19**55**, and that death occurred at **9:30p m.**, from the causes and on the date stated above.

23a. SIGNATURE Lee A. McNeely, MD		(Degree or title)		23b. ADDRESS Greenfield, MO		23c. DATE SIGNED 8-26-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-23-55		24c. NAME OF CEMETERY OR CREMATORY Pennsboro		24d. LOCATION (City, town, or county) (State) Dade Co Mo.	
DATE REC'D BY LOCAL REG. 8-27-55		REGISTRAR'S SIGNATURE J.C. Canada 478		25. FUNERAL DIRECTOR'S SIGNATURE W.R. Allison Greenfield Mo.		ADDRESS	

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..

Student.....
Signature of Student Embalmer

Signed *W. R. Allison*.....

Licensed Embalmer No. *44*

P. O. Address *Greenville*

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.