

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41925

STATE FILE NUMBER

FILED DEC 27 1956

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 187

1. PLACE OF DEATH a. COUNTY <i>Jasper</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jasper</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <i>Webb City Mo</i> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Webb City Mo</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>606 Dr. Walker</i>		Length of stay in 1b <i>10 yrs</i>		d. STREET ADDRESS (If outside, give location) <i>606 Dr. Walker</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lola</i> Middle <i>Pearl</i> Last <i>Keeling</i>			4. DATE OF DEATH Month <i>Dec</i> Day <i>16</i> Year <i>1956</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 26, 1901</i>	9. AGE (In years last birthday) <i>55</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Williams, Iowa</i>	
13. FATHER'S NAME <i>Gus Riecke</i>			14. MOTHER'S MAIDEN NAME <i>Hattie Blank</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Loy Keeling - Webb City Mo</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal pulmonary edema</i>					INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Chronic myocarditis</i>					<i>9 mon</i>
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic ulcerative cystitis</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>10/29/56</i> to <i>12/16/56</i> and last saw her alive on <i>12/16/56</i> Death occurred at <i>2:30</i> Pm on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (If Deceased or Heir) <i>Mrs. W. W. Webb</i>			22b. ADDRESS <i>Webb City, Missouri</i>		22c. DATE SIGNED <i>12/18/56</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Dec 19, 1956</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sulphur Bend Cem. &amp; Mausoleum</i>		23d. LOCATION (City, town, or county) (State) <i>Abbe</i>
24. FUNERAL DIRECTOR <i>Cooper Funeral Home, Miami Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>12-18-56</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Madeline Surtz</i>	

with, welfare public service  
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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

1956  
Health Office  
County File Number 56-12-1011  
Date Filed DEC 26 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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *Lawry E. Arue*  
Licensed Embalmer No. 48

P. O. Address *West*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.