

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044483

STATE FILE NUMBER
5911

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1959

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, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>600 W 89th TERR.</u>	Length of stay in lb <u>41 Years</u>	d. STREET ADDRESS (If outside, give location) <u>600 W. 89th TERR.</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>MARIE</u> Last <u>WEBB</u>	4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>12</u> Year <u>1958</u>
--	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 5, 1917</u>	9. AGE (In years last birthday) <u>41</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
----------------------	-------------------------------	---	---	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	---	--	---

13a. FATHER'S NAME <u>Michael MAIER</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA SALSINGER</u>	14. NAME OF HUSBAND OR WIFE <u>WILLIAM R. 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>495-24-6929</u>	17. INFORMANT <u>Mr. Wm. R. WEBB, 600 W. 89th TERR.</u>
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstances of Lungi</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MO</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) <u>Retention of Bilobarion of left</u>	<u>4 years</u>
	DUE TO (c) <u>any</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.) <u>2000</u>
---	---

20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <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 <u> </u> STATE <u> </u>
---	--	--	--

21. I attended the deceased from <u>1954</u> to <u>12-12-58</u> and last saw her <u>alive</u> on <u>12-11-58</u> Death occurred at <u>4:45/PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John T. Skinner MD</u>	22b. ADDRESS <u>1107 Grand St. CM</u>	22c. DATE SIGNED <u>12-14-58</u>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 15, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>
--	----------------------------------	---	--

24. FUNERAL DIRECTOR <u>MUEHLEBACH</u>	ADDRESS <u>6800 TROOST</u>	25. DATE RECD. BY LOCAL REG. <u>12-14-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
---	-------------------------------	---	---

John T. Skinner USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION All diseases in Part I must be causally related.

DR J. T. SKINNER
BRYANT BLDG
VI 2-7010

V
2

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 *P. E. Nichols*

Licensed Embalmer No. *4997*

P. O. Address *K. P. ...*

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.