

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021758

FILED JUL 8 1959

STATE FILE NUMBER 2999

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2999

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City.</b>		c. CITY OR TOWN <b>Kansas City,</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4 West 37 Street.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <b>23yrs.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>N</b> Last <b>Webb</b>			4. DATE OF DEATH Month <b>June</b> Day <b>19,</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 31, 1881</b>	9. AGE (In years last birthday) <b>77<sup>1/2</sup> YRS.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GALLUP MAP CO.</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>OTTAWA, KANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>M. O. WEBB</b>		13b. MOTHER'S MAIDEN NAME <b>ANNIE FULLERTON</b>		14. NAME OF HUSBAND OR WIFE <b>ETHEL A WEBB</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>487 10 3465</b>	17. INFORMANT Address <b>ETHEL A WEBB 4 WEST 37th STREET K. C. MO.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus - Mild.</b>		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 _____ a.m. _____ p.m.					

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 STATE	
21. I attended the deceased from <b>1-15-52</b> to <b>6-19-59</b> and last saw her/him alive on <b>6-18-59</b> Death occurred at <b>72:30</b> A m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <i>John H. Wheeler</i> (Degree or title)		22b. ADDRESS <b>M.D. 411 Nichols Road, K. C. Mo.</b>		22c. DATE SIGNED <b>6-19-59</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JUNE 21, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEROY CEM</b>		23d. LOCATION (City, town, or county) (State) <b>LEROY KANSAS</b>	
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24. FUNERAL DIRECTOR ADDRESS <b>DWnewcomer's Sons MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-19-59</b>		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>	
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MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE John H. Wheeler

All diseases in Part I must be causally related.

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 *James W. Tolson* .....

Licensed Embalmer No. *4889* .....

P. O. Address *D.C., Md.* .....

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.