

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-002064

FILED VS JAN 27 1960

Registration District No. 150 Primary Registration District No. 4239 Registrar's No. 8

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lee's Summit		Length of stay in 1b 50 yrs.		c. CITY OR TOWN Lee's Summit		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 608 Jefferson St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 608 Jefferson St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle ---- Last Webb				4. DATE OF DEATH Month Jan. Day 13 Year 1960				
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Jan. 11, 1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months 80 Days	IF UNDER 24 HR Hours 80 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Wales		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Williams			13b. MOTHER'S MAIDEN NAME Jane Thomas			14. NAME OF HUSBAND OR WIFE T. W. Webb (Dec.)		
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. 496-10-5945		17. INFORMANT Mrs. Nina Duncan, 1428 E. 66 Terr. Mo.			Address Kansas City
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cerebral Anoxia							30 min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Vasomotor Collapse						3 hours.	
	DUE TO (c) Bronchopneumonia						24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 10:00 a.m. Month, Day, Year May 1959	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 May 1959 to 1-13-60 and last saw her alive on 1-13-60 . Death occurred at 1-13-60 10:00 m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) William J. Rhoads M.D.				22b. ADDRESS 320 So. Douglas Lee's Summit			22c. DATE SIGNED 1-14-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 16, 1960	23c. NAME OF CEMETERY OR CREMATORY Lee's Summit Cemetery		23d. LOCATION (City, town, or county) (State) Lee's Summit, Missouri				
24. FUNERAL DIRECTOR Langsford Funeral Home Lee's Summit Mo.				25. DATE RECD. BY LOCAL REG. 1-14-1960		26. REGISTRAR'S SIGNATURE N.B. Langsford		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *N. B. Langsdorf*
Licensed Embalmer No. 496
P. O. Address *Leisler*

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