JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-029295
STATE FILE NUMBER

FILED VS JUL 25 1960 324 Registration District No. Primary Registration District No. 6093 Registrar's No. 141

ENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: Saline
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Marshall
Length of stay in 1b: 44 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Marshall State School & Hospital
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Texas
c. CITY OR TOWN: Mountain Grove
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): ----
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Edith; Middle: ---; Last: Webster
4. DATE OF DEATH: Month Day Year: 7-21-1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-13-1904
9. AGE (last birthday): 56
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HR: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Patient
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (City and state or country): Clearwater, Ks.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Oswald Z. Webster
13b. MOTHER'S MAIDEN NAME: Celia Higgins
14. NAME OF HUSBAND OR WIFE: -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Records of State School & Hosp. Address: Marshall

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
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)
Mentally retarded, epileptic, chronic invalid
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 4-1-1959, to 7-21-1960 and last saw her/him alive on 7-21-1960
Death occurred at 8:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. B. Day (Degree or title) M. D.
22b. ADDRESS: Marshall State School & Hosp., Marshall, Mo.
22c. DATE SIGNED: 7-21-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7-21-1960
23c. NAME OF CEMETERY OR CREMATORY: -
23d. LOCATION (City, town, or county) (State): Webb City, Missouri

24. FUNERAL DIRECTOR ADDRESS: Lewis Funeral Home Webb City, Mo
25. DATE RECD. BY LOCAL REG.: 7-21-60
26. REGISTRAR'S SIGNATURE: Cecil G. Read

(Licensed Embalmer's Statement on Reverse Side)

AUG 19 1960

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 Jack W. Lesser

Licensed Embalmer No. 4643

P. O. Address Marshall,

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