

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 12 1960

-60-042330

5790

STATE FILE NUMBER

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

DED

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|---|--|---|--|---|--|--|---|--|--|-------------------------------------|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 10 yrs | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3548 Park. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Joshua Middle Webb Last | | | | 4. DATE OF DEATH Month 11th Day 12th Year 1960 | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OF RACE Negro | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 12-11-87 | | 9. AGE (last birthday) 73 yrs | | 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) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (City and state or country) Morrilton, Arkansas | | 12. CITIZEN OF WHAT COUNTRY U.S. | | | | | |
| 13a. FATHER'S NAME unknown | | | | 13b. MOTHER'S MAIDEN NAME unknown | | | | 14. NAME OF HUSBAND OR WIFE Mabel Webb | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Mabel Webb (wife) Kansas City, Mo V.A. Hospital, Kansas City, Mo | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATIIN PNEUMONIA, BILATERAL | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GENERALIZED PERITONITIS WITH MULTIPLE PERITONEAL ABSCESSSES FOLLOWING PARTIAL COLECTOMY FOR CARCINOMA OF SPLENIC FLEXURE. | | | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | 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 a.m. p.m. | | Month, Day, Year | | | | | | | | | | | |
| 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 VA | | COUNTY | | STATE | | | | | |
| 21: / attended the deceased from October 13, 1960 to November 12, 1960 Death occurred at 2:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>H. Choy</i> | | | | (Degree or title) | | | | 22b. ADDRESS MD V.A. Hospital, Kansas City, Mo | | 22c. DATE SIGNED 11-12-60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 11-18-60 | | 23c. NAME OF CEMETERY OR CREMATORY National Cemetery | | | | 23d. LOCATION (City, town, or county) (State) Fort Leavenworth, Kans. | | | | | |
| 24. FUNERAL DIRECTOR Mrs. Meek's Mortuary, K. C. Mo. | | | | 25. DATE RECD. BY LOCAL REG. 11-17-60 | | 26. REGISTRAR'S SIGNATURE <i>H. L. Dwyer</i> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. Choy

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Willard B. Paster

Licensed Embalmer No. 501

P. O. Address KC

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