

Registration District No. **398**

Primary Registration District No. **5554**

Registrar's No. **338**

1. PLACE OF DEATH
(a) County **Jackson**
(b) City or town **Mount Washington**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **802 Arlington 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Mary L. Webb**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **George Webb**
6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **Nov 19 - 1869**
(Month) (Day) (Year)

8. AGE: Years **69** Months **11** Days **19** If less than one day _____ hr. _____ min.

9. Birthplace **Seneca New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

MOTHER FATHER
12. Name **unknown**
13. Birthplace **unknown New York**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **George Webb**
(b) Address **802 Arlington**

17. (a) **Burial** (b) Date thereof **11-10-39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Fen**

18. (a) Signature of funeral director **George C. Carson**
(b) Address **Independence Mo**

19. (a) **11-13-39** (b) **L. H. Coop**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Mount Washington**
(If outside city or town limits, write "RURAL")
(d) Street No. **802 Arlington**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **8**
year **1939** hour **4** minute **30 P** M.

21. I hereby certify that I attended the deceased from **9/6**, 19**36**, to **11/8**, 19**39**;
that I last saw her alive on **11/8**, 19**39**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis** Duration _____
Due to **Hypertension**
Due to **Ch. Nephritis**
Other conditions **Optic Atrophy**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **William M. D.** (M. D. or other) _____
Address **10307 Indep Ave Kc Mo** Date signed **11/10/39**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.