

FILED OCT 7 1942

Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Webb City
(c) Name of hospital or institution James H. Brown Hospital
(d) Length of stay: In hospital or institution (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Infant of Jack Left

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 23 1942 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 13 hr. min.

9. Birthplace Webb City Missouri (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Child

MOTHER FATHER { 12. Name Jack Left
13. Birthplace Carterville Missouri
14. Maiden name Mrs. Taylor
15. Birthplace Missouri

16. (a) Informant Jack Left
(b) Address 411 W. Penn. Webb City Mo

17. (a) Burial (b) Date thereof Sept 25 1942 (c) Place: burial or cremation Missouri

18. (a) Signature of funeral director Webb City Undert Co
(b) Address 208 E. 1st St. Webb City Mo

19. (a) Sept 25 1942 (b) Mrs. Lillie Lagle (c) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Webb City
(d) Street No. 411 W. Penn Ave
(e) If foreign born, how long in U. S. A. 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24 year 1942 hour 10:00 minute 0 M.

21. I hereby certify that I attended the deceased from Sept 23 1942 to Sept 24 1942 that I last saw her alive on Sept 24 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Remoter Birth

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____
(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 P. H. Brown (M. D. or other) Date signed 9/27/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

49
6
2

49

2

0

24

10:00

0

Sept 23

Sept 24

1942

1942

159

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 A. H. Mills

Licensed Embalmer No. 347

P. O. Address West City, Mo

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.