

FILED MAR 22 1944

State File No. _____

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 220

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
In this community 3 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 921 North 24th
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME

MARY E. 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, widowed 2

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

7. Birth date of deceased July 13 1935 (Month) (Day) (Year)

8. AGE: Years 88 Months 7 Days 8 If less than one day hr. min.

9. Birthplace Marion county Indiana (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Rev. Daniel Kempton

13. Birthplace unknown England (City, town, or county) (State or foreign country)

14. Maiden name Mary Cochran

15. Birthplace unknown unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. N. Stevenson

(b) Address St. Joseph, Mo.

17. (a) Removal (b) Date thereof 2/22/44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Des Moines, Iowa

18. (a) Signature of funeral director Beble & Bowman

(b) Address 319 South 10th Street,

19. (a) 2/22/44 (b) Rose Herzog (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21 year 1944 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 11 1944 to Feb 21 1944 and that death occurred on the date and hour stated above

Immediate cause of death Angina pectoris Duration

Due to Acute

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

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 O. W. Reed (M.D. or other)

Address 408 Cash Bed Date signed Feb 23/44

1233

(Licensed Embalmer's Statement on Reverse Side)

St. Joseph, Mo.

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

3
9
5671

Dr. O. H. Weed
Conly Bldg.

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 Frank A. Conway

Licensed Embalmer No. 1710

P. O. Address St. Joseph 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, fact should be so stated above.