

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36871

State File No. ....

Registration District No. 167

Primary Registration District No. 3040

Registrar's No. 130

**1. PLACE OF DEATH:**

(a) County Livingston

(b) City or town Chillicothe  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
#16 Martin 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 6 yrs.  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Livingston <sup>59</sup>

(c) City or town Chillicothe  
(If outside city or town limits, write "RURAL")

(d) Street No. #16 Martin <sup>3</sup>  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) <sup>2</sup>

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** William O. Webb

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

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Oct. day 29  
year 1946 hour 2 minute 10 P.-M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eva E. Webb 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased: October 23 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 7 1946 to Oct 29 1946  
that I last saw him alive on Oct 22 1946  
and that death occurred on the date and hour stated above.

8. **AGE:** Years: 76 Months: 0 Days: 6 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Wremia <sup>Duration 14 Days</sup>

Due to Prostate Hypertrophy <sup>5 yrs</sup>

Due to \_\_\_\_\_

9. Birthplace Unionville Chillicothe  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

**PHYSICIAN** \_\_\_\_\_

10. Usual occupation Laborer

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_ <sup>137A</sup>

Underline the cause to which death should be charged statistically.

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name John Webb

13. Birthplace Unionville \_\_\_\_\_ <sup>7</sup>  
(City, town, or county) (State or foreign country)

14. Maiden name Unionville

15. Birthplace Unionville \_\_\_\_\_ <sup>4</sup>  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant Charles Weas

(b) Address St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/46  
(Month) (Day) (Year)

(c) Place: burial or cremation Edgewood Cemetery

(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? \_\_\_\_\_

18. (a) Signature of funeral director Donald Gordon

(b) Address Chillicothe, Mo.

19. (a) Oct-30-46 (Date received local registrar) (b) Frances B. Neall (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Edgar Palmer (M. D. or other) <sup>5</sup>

Address Chillicothe Mo. Date signed Oct 30/46

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

32939

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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..... *Wayne T. Collins* .....  
Licensed Embalmer No..... *1164* .....  
P. O. Address..... *Chillicothe* .....

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.