

S. No. 2
M-8-43
v. 5-17-39
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24473

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 6 1947
Registration District No. 1947/6

Primary Registration District No. 3026

Registrar's No. 227

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Independence Sanitarium & Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether)

In this community 61 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Grain Valley - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 5 mi. W. West
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Grace Elizabeth Webb

3. (b) If veteran, name war -

3. (c) Social Security No. -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1947 hour 1 minute 23 p.m.

21. I hereby certify that I attended the deceased from 7/1, 1947, to 7/22, 1947;

4. Sex F m 5. Color or race W

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

6. (b) Name of husband or wife C. O. Webb

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased July 18 - 1886
(Month) (Day) (Year)

that I last saw h. alive on 7/1, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Failure
Bronchiectasis - Bilateral

Due to Bilateral

Due to

8. AGE: Years 61 Months 0 Days 4
If less than one day hr. min.

9. Birthplace Buckner Mo
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 106B

Of autopsy See Above

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation House wife

11. Industry or business House wife

12. Name James Tucker

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

14. Maiden name Anna Reynolds

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

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? _____

16. (a) Informant C. O. Webb

(b) Address Grain Valley Mo

17. (a) Burial (b) Date thereof 7-24-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland Cemetery

18. (a) Signature of funeral director W. B. Webb, Sr.

(b) Address Burlington Mo

19. (a) 7-24-47 (b) James Tucker
(Date received local registrar) (Registrar's signature)

While at work (Specify time of day) 10:00 (Specify nature of injury) ?

23. Signature A. E. Upcher (M. D. or other) Mo
Address 2800 1/2 Main Date signed 7/23/47

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

MOTHER FATHER

AUG 18 1953

FEB 6 1953

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..... *RB Webb*

Licensed Embalmer No. *2353*

P. O. Address *Blue Springs Va*

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.