

FILED OCT 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30649

State File No. ....

3923

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mountain View</u>	
c. LENGTH OF STAY (In this place) <u>4 weeks</u>		d. STREET ADDRESS (If rural, give location) <u>X O</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Osteopathic Hospital 10</u>			

3. NAME OF DECEASED a. (First) <u>Samuel</u> (Type or Print)			b. (Middle) <u>W</u>			c. (Last) <u>Webb</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 12 1949</u>						
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			8. DATE OF BIRTH <u>Jan 28-1876</u>						
9. AGE (In years last birthday) <u>73</u>			UNDER 1 YEAR Months			IF UNDER 2 HRS. Days			Hours Min.						
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			

13a. FATHER'S NAME <u>John D Webb</u>			13b. MOTHER'S MAIDEN NAME <u>-</u>			14. NAME OF HUSBAND OR WIFE <u>Michael Webb</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT'S SIGNATURE OR NAME <u>Wm Harry Strickler</u>			ADDRESS <u>Kans. City, Mo.</u>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Septicemic pneumonia</u>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Septicemic pneumonia</u>							
		DUE TO (c) <u>Pneumonia of lungs</u>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hydro-nephrosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Septicemic pneumonia</u>						20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6/17/49 to 9/12/49, that I last saw the deceased alive on 9/11/49, 1949, and that death occurred at 4:24 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>A. A. Choquette</u> (Degree or title)		23b. ADDRESS <u>929. Brown Bldg</u>		23c. DATE SIGNED <u>9/12/49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Sept-12-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Mountain View Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>9-12-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. L. Foster</u>		ADDRESS <u>Kansas City, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 16 1949

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Dean Owens*

Licensed Embalmer No.

4280

P. O. Address

K. C., 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.