

FILED JAN 14 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. R. Webb

947

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>138</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>22</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>10 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		1395	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1431 N. Ethel</u>				d. STREET ADDRESS (If rural, give location) <u>1431 N. Ethel</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lucinda</u>		b. (Middle) <u>Ellen</u>		c. (Last) <u>Snyder</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 7, 1952</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 5 1875</u>		9. AGE (In years, last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Arron Kimbrough</u>		13b. MOTHER'S MAIDEN NAME <u>Charity McGuire</u>		14. NAME OF HUSBAND OR WIFE <u>X</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>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ben Snyder Springfield, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) <u>Carcinoma of the Rectum</u> ANTECEDENT CAUSES Morbid conditions, (if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>13 mo.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>154X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.		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 <u>11-12</u> , 19 <u>50</u> , to <u>1-8</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>Nov</u> , 19 <u>52</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. Richard Webb, M.D.</u>				23b. ADDRESS <u>604 Cherry St. Springfield, Mo.</u>		23c. DATE SIGNED <u>1-8-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/10/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Old Union Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>N. of Mt. Grove, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>1-10-52</u>		REGISTRAR'S SIGNATURE <u>James R. Ambs, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. H. Lohmeyer Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Paul Schmiedt*

Licensed Embalmer No. *4737*

P. O. Address *Spokane, 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.