

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13975
STATE FILE NUMBER

FILED MAY 15 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 179

Health, & Welfare Public Service
S. 300 1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. securing the medical certification in the appropriate manner required by statute. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Hannibal</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Vandalia</u> <u>0041</u> <u>0</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth's Hosp</u>			Length of stay in 1b <u>1</u>	d. STREET ADDRESS <u>501 East Washington</u>		
3. NAME OF DECEASED (Type or print) <u>Grover Thurman Webber</u>			First <u>Grover</u>	Middle <u>Thurman</u>	Last <u>Webber</u>	
4. DATE OF DEATH <u>May 8, 1957</u>	Month <u>May</u>	Day <u>8</u>	Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13, 1888</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	11. BIRTHPLACE (City and state or country) <u>Ladonia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Edward D. Webber</u>			14. MOTHER'S MAIDEN NAME <u>Anna L. Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs Lula Webber, Vandalia, Missouri</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>My cerebral infarct Posterior lateral</u> <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<u>4201</u>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>12:27</u> Month, Day, Year a. m. <u>PM</u> p. m.						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from <u>May 9 1957</u> , to <u>May 8 1957</u> and last saw <u>her</u> alive on <u>May 8 1957</u> Death occurred at <u>12:27 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Harold L. Truman M.D.</u> (Degree or title)		22b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>		22c. DATE SIGNED <u>5-10-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 10, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Vandalia, Missouri</u>			
FUNERAL DIRECTOR <u>William B Waters</u>	ADDRESS <u>Vandalia, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5/11/57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luckey by V. C. Fisher</u>			

RECEIVED MAY 14 1957
MARION CO. HEALTH DEPT.,
DATE FILED MAY 14 1957

MAR 19 1958

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.....
Signature of Student Embalmer

Signed *William S. Water*

Licensed Embalmer No. *416*

P. O. Address *Vandalia*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

noted & corrected