

FILED OCT 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32786

STATE FILE NUMBER

Registration District No. 248 Primary Registration District No. 4369 Registrar's No.

300 2
1-57

1. PLACE OF DEATH a. COUNTY <u>Newton</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Elk</u>		
b. CITY OR TOWN <u>Seneca</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Elka Falls</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Jail</u>		Length of stay in 1b <u>6 hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>1 mi N.W. of city</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Ralph</u> Last <u>Webb</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-8-1908</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Elk Co. Kas.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Wm. Webb</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u> </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. <u>509-14-4295</u>	17. INFORMANT <u>Records in billfold</u> Address <u> </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>Suffocate Burned mattress in small room</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>55 % Carbon Monoxide saturation of the</u> DUE TO (c) <u>Blood</u> <u>9/67</u>					INTERVAL BETWEEN ONSET AND DEATH <u>40</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Burned mattress in small room</u>			
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u>Sept. 13-57</u> a.m. <u> </u> p.m. <u> </u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>City Jail</u>		20f. CITY, TOWN, OR LOCATION <u>Seneca</u> COUNTY <u>Newton</u> STATE <u>Missouri</u>		
21. I attended the deceased from <u>Sept. 13-57</u> to <u>Sept. 13-57</u> and last saw her alive on <u> </u> Death occurred at <u>1 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Paul H. Jones</u> (Degree or title) <u>Coroner</u>			22b. ADDRESS <u>Neosho, Missouri</u>		22c. DATE SIGNED <u>9/20/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reburied</u>	23b. DATE <u>9-13-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moline Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Moline Kas.</u>	
24. FUNERAL DIRECTOR <u>W. E. Bell</u> ADDRESS <u>Seneca Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-25-57</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Irene Russell</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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RECEIVED

District Health Officer No. Newton

District File Number 957-221

Date Filed SEP 3 9 1957

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 W. B. Allison

Licensed Embalmer No. 2174
P. O. Address Seneca 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.