

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI <sup>24907-58</sup>  
STANDARD CERTIFICATE OF DEATH

58-010262  
STATE FILE NUMBER  
1375

FILED APR 2 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 8150

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-57

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Kansas City</b>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Stilwell</b><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>  |                                  | Length of stay in 1b<br><b>2Hrs.</b>  | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle Last <b>Webb</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>3</b> - Day <b>14</b> - Year <b>58</b>   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>3-14-1958</b>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.<br><b>2</b>                         |
| 11a. BIRTHPLACE (City and state or country)<br><b>Kansas City, Mo.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13a. FATHER'S NAME<br><b>Charles Webb</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Lois Mace</b>   | 14. NAME OF HUSBAND OR WIFE<br>---  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Charles Webb</b> Address <b>Stilwell, Ks.</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anoxia</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Prematurity</b><br>DUE TO (c) _____<br>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<br><b>76.5</b>   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 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<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |                                  | 20d. INJURY OCCURRED WHILE AT <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 <b>MAR 14-1958</b> to <b>3-14-58</b> and last saw her alive on <b>Mar 14-1958</b><br>Death occurred at <b>MAR 14, 1958 6:50 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  | 21. I attended the deceased from <b>MAR 14-1958</b> to <b>3-14-58</b> and last saw her alive on <b>Mar 14-1958</b><br>Death occurred at <b>MAR 14, 1958 6:50 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |   |
| 22a. SIGNATURE (Degree or title)<br><b>Robert C. Buckner M.D.</b>   |                                  | 22b. ADDRESS<br><b>4670 J.C. Nichols Pkwy KCMo</b>  |   |
| 22c. DATE SIGNED<br><b>Mar 14, 1958</b>   |                                  | 22c. DATE SIGNED<br><b>Mar 14, 1958</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>3-15-58</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Johnson Co. Memorial Gardens, Johnson Co, Ks.</b>                                  |
| 24. FUNERAL DIRECTOR<br><b>Freeman Mortuary- KC, Mo.</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>3-15-58</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Irene Minshall</b>  |

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Robert C. Buckner  
All diseases in Part I must be causally related.

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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. *Not Embalmed arterial*

Student .....  
Signature of Student Embalmer

Signed *Rayton Barnes* .....

Licensed Embalmer No. *4793* .....  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. -  
If this body is not embalmed, fact should be so stated above.