

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009519

STATE FILE NUMBER

FILED VS. FEB. 23 1966 237

Registration District No. 237 Primary Registration District No. _____ Registrar's No. 13

ENDED

1. PLACE OF DEATH a. COUNTY <u>Shelby</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Shelbyville</u> Length of stay in 1b <u>24 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pleasant Hill Rest Home</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Shelby</u> c. CITY OR TOWN <u>Shelbina</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Shelbina, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <u>Mollie</u> Middle <u>E.</u> Last <u>Webb</u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1960</u>				
5. SEX <u>Female</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>7-23-1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Feeble Minded</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Shelby County</u>		12. CITIZEN OF WHAT COUNTRY <u>usa</u>	
13a. FATHER'S NAME <u>Walter Webb</u>			13b. MOTHER'S MAIDEN NAME <u>Anne Sites</u>			NAME OF HUSBAND OR WIFE <u>None</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>none</u>		17. INFORMANT <u>W.T. Webb Quincy, Ill.</u> Address _____			
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>Influenza</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterio Sclerosis</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____		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>Feb. 5 1960</u> to <u>Feb. 12 1960</u> and last saw her <u>alive on Feb. 9 1960</u> Death occurred at <u>12:10 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>F.G. Quaker M.D.</u> (Degree or title)			22b. ADDRESS <u>Shelbyville, Mo</u>		22c. DATE SIGNED <u>2-15-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 13, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>		23d. LOCATION (City, town, or county) (State) <u>Shelbina, Missouri</u>			
24. FUNERAL DIRECTOR <u>Greening Shelbyville, Missouri</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>Feb-15-1960</u>		26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Charles W. Rice

Licensed Embalmer No. 4425
P. O. Address Lawrence

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.