WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. 4664 Labadie Av. St. N Ward)

Registration District No. 791 File No. 28283

Primary Registration District No. 1003 Registered No. 8160

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alvin Stith Webb

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb (Month) 8 (Day) 1854 (Year)

7 AGE: 64 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Metal worker
(b) General nature of industry business, or establishment in which employed (or employer): Armor Packing Co

9 BIRTHPLACE (City or town, State or foreign country): Cincinnati Ohio

PARENTS

10 NAME OF FATHER: John H. Webb

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Newport Ky

12 MAIDEN NAME OF MOTHER: Francis Horritt

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Clara Webb
(Address) 4664 Labadie

15 Filed AUG 27 1918, 191 Max C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. (Month) 25th (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h.....alive on ....., 191.....
and that death occurred, on the date stated above, at 9-30 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial
130 131 Nephritis
Y. M. C.
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs....mos....ds.

(Signed) H. W. Fath M. D.
8/27, 1918 (Address) Deputy Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted if not at place of death? .....
Former or usual residence 4664 Labadie Av

19 PLACE OF BURIAL OR REMOVAL: Zions Cemetery — DATE OF BURIAL: Aug 28, 1918

20 UNDERTAKER: R. H. Askemeyer — ADDRESS: 4639 Cottage Av

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

..... 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

20 UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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