APR 27 1927

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

Do not use this space.

8982

1. PLACE OF DEATH
County: Mississippi — Registration District No.: 569
Township: Ohio — Primary Registration District No.: 5745
City: ..... (No. ....., ... St. ..... Ward)
File No.: ..... Registered No.: .....

2. FULL NAME: John Webb

(a) Residence: No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Lou Webb

6. DATE OF BIRTH (MONTH, DAY AND YEAR): About 1839

7. AGE: Years: About 88 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Quincy
(STATE OR COUNTRY): Ill

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): .....
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): .....

14. INFORMANT: J. W. Webb
(Address): Charleston Mo. R. 4

15. FILED: 3/24, 1927 — A. Marshall, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3/23 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Saw no Physician
from history Suppd nephritis
132 A
1 1/2 yr (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Senility
(duration) ..... yrs. ..... mos. ..... ds.

12 9 13

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) A. D. Marshall, M. D
March 24, 1927 (Address) Illmo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Rush Ridge — DATE OF BURIAL: 3/25 1927
20. UNDERTAKER: Private — ADDRESS: Charleston Mo

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.