

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS 799  
CERTIFICATE OF DEATH

Do not use this space.

✓ 17208

1. PLACE OF DEATH

County Saline

Registration District No. 4479

Township Slater Mo

Primary Registration District No. 799

City Slater Mo

File No. \_\_\_\_\_

Registered No. 31

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Mary Catherine Webb

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

4. COLOR OR RACE

White

5. ~~SINGLE~~ MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

John F Webb

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 10 - 1855

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>71</u>	<u>8</u>	<u>19</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Nevada  
(STATE OR COUNTRY)

10. NAME OF FATHER Wm Gross

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Katie Bert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky  
(STATE OR COUNTRY)

14. INFORMANT Mrs Roy Hicks  
(Address) Slater Mo

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Apr 27, 1927, to May 29, 1927, that I last saw him alive on May 29, 1927, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

fractured hip  
1869  
1945 ✓  
162  
CONTRIBUTORY Senility  
(SECONDARY)  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH. \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH. \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) Geo Arthur M. D.  
Slater Mo  
, 19 (Address)

\*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 Slater City Cemetery DATE OF BURIAL May 30 1927

20. UNDERTAKER Jones & Salger ADDRESS Slater Mo

K. 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.

RECORD WITH OBTAINING INK—THIS IS A PERMANENT RECORD



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Saline

Registration District No. 799

File No. ....

Township Slater

Primary Registration District No. 4479

Registered No. 31

City Slater (No. .... St. .... Ward)

**2. FULL NAME**

Mary Catherine 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED, 19... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1927

17. I HEREBY CERTIFY, That I attended deceased from ... that I last saw h. .... alive on ... death occurred, on the date stated above, at ...

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Fractured hip fall. not intentional

CONTRIBUTORY (SECONDARY) Senility

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH...

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. Caldwell, M. D. , 19 (Address) Slater Mo.

\*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1925

