

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.

B 22 1929

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

1959

1. PLACE OF DEATH

County Jackson
Township Oak Grove
City Oak Grove (No. _____) St. _____ Ward _____

Registration District No. 402
Primary Registration District No. 4237

File No. _____
Registered No. 6

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

6A. IF MARRIED, WIDOWED OR DIVORCED, HUSBAND OF (OR) WIFE OF Charles B. Church

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/23-1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
66 10 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife
(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) Mo.

10. NAME OF FATHER Curran Webb

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

12. MAIDEN NAME OF MOTHER Eliza Cinda Ann Phillips

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

14. INFORMANT W. Church
(Address) Oak Grove, Mo.

15. FILED Jan 30 1929 A. W. Mann
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 20 1929

17. HEREBY CERTIFY That I attended deceased from Jan. 20, 1929, to Jan. 20, 1929.
that I last saw h. en alive on Jan. 20, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral thrombosis

CONTRIBUTORY (SECONDARY) Arteriosclerosis

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? clinical

(Signed) W. H. B. M. D.

1/22, 1929 (Address) Oak Grove, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Oak Grove, Mo. 1/22 1929

20. UNDERTAKER ADDRESS

W. H. B. Oak Grove, 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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Township..... City..... (No.) Registration District No. Primary Registration District No. File No. Registered No. Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

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. 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)

PARENTS

14. INFORMANT (Address)

15. FILED 19... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19...

17. I HEREBY CERTIFY, That I attended deceased from that I last saw him alive on 19... to 19... and that death occurred, on the date stated above, at THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

, 19 (Address)

M. D

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19