

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

Do not use this space.

APR 24 1929

File No. **9842**

1. PLACE OF DEATH

County Cape Registration District No. 130
 Township Franklin Primary Registration District No. 4073
 City Allenville White Water St. _____ Ward _____

2. FULL NAME

William Rufus 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)** Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 18-1867

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, — hrs. or — min.**
61 3 22

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) near Jackson
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER William Webb

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

12. MAIDEN NAME OF MOTHER Rebecca Hendricks

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

14. INFORMANT Wiley Webb
 (Address) Jackson RFD #5

15. FILED 3/16/29 J.M. Slagle
 1929 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-11-1929

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1929, to March 10, 1929
 that I last saw him alive on March 4, 1929, and that death occurred, on the date stated above, at 12 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis

2.5A / pulmonary
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

18. DID AN OPERATION PRECEDE DEATH: DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. S. Markel, M.D.

, 19 (Address) Allenville 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 Moore Cemetery **DATE OF BURIAL** Mar 12 1929

20. UNDERTAKER Crockett Miller **ADDRESS** Jackson 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.

100

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

7842
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cape

Registration District No. 130

File No.

Township

Primary Registration District No. 4073

Registered No.

City White Water (No.) St. Ward)

2. FULL NAME William Rufus 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 (Use the word)

s

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

3/16 29 J.M. Seagle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-11-29

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tuberculosis
Pulmonary
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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) M. D. , 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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC

Every important.

No. 017 item of information should be carefully copied. AGE MISSING BE

SUPPLEMENTARY

5-9842