

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

Do not use this space.

Powell 8716

1. PLACE OF DEATH

County *Jackson* Registration District No. *399* File No. _____
 Township *Kaul* Primary Registration District No. *1002* Registered No. *1003*
 City *St. Louis* (No. *Wesley Hospital*) St. _____ Ward _____

2. FULL NAME

Willis Allen Webb
 (a) Residence No. _____ St. _____ Ward *Grand Pass Mo*
 (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 *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Single*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 9-1860*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 3 2
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Retiree Farmer*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Saline Co Mo.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Samuel Webb*

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

12. MAIDEN NAME OF MOTHER *unknown*

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

14. INFORMANT *J P DeMoss*
 (Address) *Chelsea Mo.*

15. FILED *3/11 30 M.M. Crover*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-11-1930*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 18-1930* to *Mar 11-1930*
 that I last saw him alive on *3-11-1930* and that death occurred, on the date stated above, at *11-30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic Nephritis
 followed by
 uremia
 183
 131* (duration) *2* yrs. _____ mos. _____ ds.

CONTRIBUTORY (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) *B B Powell* M. D.
 3-11-1930 (Address) *926 Me-See*

*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 *Grand Pass Mo.* DATE OF BURIAL *3/13/30*

20. UNDERTAKER *Blind's* ADDRESS *Chelsea*

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.

