

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.

Dr. Vernon
 NOV 26 1935

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

Do not use this space.

33394

1. PLACE OF DEATH

County *Mississippi*
 Township *S. 1st*
 City *Anniston, Mo.* (No.)

Registration District No. *1267*
 Primary Registration District No. *6803*

File No.
 Registered No. *69*
 St. Ward

2. FULL NAME *Alvin Monroe Webster*

(a) Residence, No. *Anniston, Mo.* St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Arbell Webster</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Sept-10-1858</i>		
7. AGE	YEARS <i>82</i>	MONTHS <i>1</i>
	DAYS	IF LESS than 1 day, hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	<i>Farming</i>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	<i>Life</i>

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *W. Va.*

13. NAME *John Webster*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Georgia*

15. MAIDEN NAME

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

17. INFORMANT *B. E. Webster*
 (ADDRESS) *Anniston, Mo.*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE *Anniston, Mo.* DATE *Oct. 12 1935*

19. UNDERTAKER *Travis M. Shelby*
 (ADDRESS) *East Branch, Mo.*

20. FILED *Oct 10 1935* *W. Huff M. Hodges*
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct-10* 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 29th* 19*35* to *Oct 10* 19*35*
 I last saw *him* alive on *Oct-7* 19*35*. Death is said to have occurred on the date stated above, at *10:30* a.m.

The principal cause of death and related causes of importance were as follows:

Apoplexy
Cerebral Thrombosis
Chronic Nephritis
Senility

Name of operation Date of
 What test confirmed diagnosis autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*
 If so, specify

(Signed) *Frank S. Vernon* M. D.
 (Address) *Charleston Mo.*

