

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.

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

39440
 Do not use this space.

1. PLACE OF DEATH.
 (a) County Pinecroft Registration District No. 656
 (b) Township Coater Primary Registration District No. 5873 Registered No. _____
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Billie R. Webster
 (a) Residence, No. Tyler, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20 1940

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	3	8	8	

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

FATHER 13. NAME Claud Webster
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER 15. MAIDEN NAME Matha Dismuke
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

17. INFORMANT (ADDRESS) Claud Webster, Tyler, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Clifton, Tenn. DATE 9 29 40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hanna Funeral Home, Bethelville, Ark.

20. FILED 10-10-40 Yonkers Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28 1940

22. I HEREBY CERTIFY, That I attended deceased from Sept 20th 1940 to Sept 28, 1940
 I last saw him alive on Sept 24th, 1940. Death is said to have occurred on the date stated above, at 3:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Colitis
11/10

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an 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? _____
 If so, specify _____ (Signed) CHM Mason, M. D.
 (Address) Tyler, Mo.

12-40-23

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.