

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 26 1942

Registration District No. _____

Primary Registration District No. 3030

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston, Miss. Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 30 mo
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

(c) City or town Charleston, Miss. Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TOM WEBSTER

3. (b) If veteran, name war _____

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17th
year 1940 hour 12.30 minute P. M.

21. I hereby certify that I attended the deceased from on Dec 14, 1940, to Dec 14, 1940.

that I last saw him alive on Dec 14, 1940,
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Col

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 26-1911
(Month) (Day) (Year)

Immediate cause of death _____
Pulm. Tuberculosis

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

8. AGE: Years 30 Months 9 Days 26
If less than one day _____ hr. _____ min.

9. Birthplace Mississippi Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Day laborer

11. Industry or business _____

12. Name Henry Webster

13. Birthplace Wofford, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Lacy Swank

15. Birthplace Mississippi Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Lacy Webster

(b) Address Charleston, Mo.

17. (a) Burial (b) Date thereof 12-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, Charleston

18. (a) Signature of funeral director Frank Shelby

(b) Address East Prairie, Mo.

19. (a) _____ (b) MAE (Registrar's signature)
(Date received local registrar)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. Chas. Ralving (M. D. or other) _____
Address Charleston, Miss. Date signed 12/19/40

Duration _____

D.K.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 142-34

Date Filed 1-16-42

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

Frank Shelby

Licensed Embalmer No.

2726

P. O. Address

East Prairie, Mo.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2908

Registration District No. 564

Primary Registration District No. 3030

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Tom Webster

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 26 (Month) (Day) (Year)

8. AGE: Years 36 Months 9 Days 16 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-5-42 (Date received local registrar) (b) F. J. Vanman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day _____ year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____

that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

