DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6557

FILED MAR 8 1943

Registration District No. 1652 Primary Registration District No. 4241 Registrar's No.

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

**1. PLACE OF DEATH:**
(a) County: Jackson
(b) City or town: Oak Grove (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 years, months or days) In this community: 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Missouri (b) County: Jackson
(c) City or town: Oak Grove (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: 0

3. (a) PRINT FULL NAME: Zeddie O. Webb
3. (b) If veteran, name war: World war #1
3. (c) Social Security No. -

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Lista
6. (c) Age of husband or wife if alive: 57 years
7. Birth date of deceased: Oct (Month) 20 (Day) 1889 (Year)

8. AGE: Years 53 Months 3 Days 24 If less than one day ..... hr. ..... min.

9. Birthplace: Grain Valley (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation: Undertaker
11. Industry or business: Undertaker
FATHER 12. Name: Geo. B. Webb
FATHER 13. Birthplace: Carol Co. (City, town, or county) Mo. 0 (State or foreign country)
MOTHER 14. Maiden name: Sarah Dodson
MOTHER 15. Birthplace: / (City, town, or county) Indiana / (State or foreign country)
16. (a) Informant: Sarah M. Webb
(b) Address: Blue Springs Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-15-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Grove Mo
18. (a) Signature of funeral director: Mrs G. B. Webb - Sm
(b) Address: Oak Grove Mo
19. (a) Feb. 16, 1943 (Date received local registrar) (b) Mary P. La Plante (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 13 year 1943 hour 10 minute 45 M.
21. I hereby certify that I attended the deceased from 1940, 19..., to Feb-13, 1943, that I last saw him alive on Feb-13, 1943, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Nephritis acute glomerular | 6 Mos |
| Due to: High blood pressure | 3 years |
| Due to: | |
| Other conditions: none (Include pregnancy within 3 months of death) | |
| Major findings: Of operations: none | |
| Of autopsy: none | |

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no.
(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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: O. Linton (M.D. or other)
Address: Oak Grove Mo. Date signed:

1010

(Licensed Embalmer's Statement on Reverse Side)

MAR 25 1943

MAR 17 1943

## 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 R Burnt

Licensed Embalmer No. 2353

P. O. Address Blue Springs Mo

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

**If this body is not embalmed, fact should be so stated above.**

No. ... 2B
9-... 1-41-41
-1¼ X2288

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**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Oak Grove (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 years, months or days)

In this community 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Jackson

(c) City or town Oak Grove (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** Reddie O Webb

3. (b) If veteran, name war World war I

3. (c) Social Security No. —

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Oct 20 (Month) — 1884 (Day) (Year)

**8. AGE:** Years 53 Months 3 Days 24 If less than one day ..... hr. ..... min.

9. Birthplace Mo (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) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 13 year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw h... alive on ..... 19...; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Nephritis — acute glomerular | |
| Due to Hiph blood pressure. This did not follow | 2 yrs |
| Due to chronic nephritis — | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations 130

Of autopsy .....

PHYSICIAN — Underline the cause to which death should be charged statistically.

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature O. Liston D (M. D. ~~or other~~)

Address Oak Grove Mo. Date signed 3-28-43

SUPPLEMENTARY