

No. 2
17-36
X29484

Dr. Webb 21395

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

ED JUN 28 1943

Registration District No. 378

Primary Registration District No. 2000

Registrar's No. 488

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
905 Colonial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community 6 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Springfield, 9
(If outside city or town limits, write "RURAL") 6
(d) Street No. 905 Colonial
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William Loren Webb

3. (b) If veteran, name war Unknown 3. (c) Social Security No. None

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Carrie Webb 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased December 19, 1855
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 24 If less than one day hr. min.

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

10. Usual occupation Retired farmer

11. Industry or business On Farm

MOTHER FATHER

12. Name Joseph Webb

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

14. Maiden name Elizabeth Cockrell

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

16. (a) Informant Mrs. Zoe Nelson
(b) Address Springfield, Missouri

17. (a) Removal (b) Date thereof June 14, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany, Missouri

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri

19. (a) 6-14-43 (b) B W Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13,
year 1943 hour 4 minute P.M.

21. I hereby certify that I attended the deceased from Dec. 19, 36 to June 14, 1943
that I last saw him alive on June 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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

23. Signature Dr. Webb (Specify type of place) (Means of injury)
Address 700 Medical Arts (M. D. or other) M.D.
Date signed 6/14/43

98K (Licensed Embalmer's Statement on Reverse Side)

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

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 Lewis G. Scharpf

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. JUL
Registrar's No. 488

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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)

3. (a) PRINT FULL NAME William Loren Webb

3. (b) If veteran, name war. 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. Dec 19 (Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 4 If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name (City, town, or county) (State or foreign country)
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)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 3
Year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19
that I last saw him alive on and that death occurred on the date and hour stated above
immediate cause of death hypostatic pneumonia
Lobar

Duration

Due to
Due to
Other conditions (include pregnancy within 3 months of death) 108

Major findings:
Of operations
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) (e) Means of injury
23. Signature William L. Webb (M. D. or other)
Address Springfield, MO. Date signed

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

SUPPLEMENTAL

S-21395