FILED SEP 6 1944

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

27506

Do not use this space.

1. PLACE OF DEATH
(a) County Clark — Registration District No. 70
(b) Township Vernon — Primary Registration District No. 5284 — Registered No. 48
or
(c) City Alexanderia — (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 3 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Larkin Danial Webster
(a) Residence, No. Alexanderia Missouri 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 22, 1864

7. AGE: 80 YEARS 80 MONTHS 6 DAYS 8 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Farming
10. Date deceased last worked at this occupation (month and year) 1941
11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dumas Cole Co. Mo

FATHER
13. NAME Johnathan Webster
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER
15. MAIDEN NAME Magnel Webster
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Mina Webster Alexanderia

18. BURIAL, CREMATION, OR REMOVAL
PLACE Fargo City DATE Aug 30 1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. W. DeJong Keokuk, Iowa

20. FILED Aug 29 1944 Perry S. Boston Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 28 1944

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 8 a.m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Fared Dead
Natural Causes
Probably Myocarditis

Other contributory causes of importance:

93e1

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) L. McDonald Coroner, M. D.
(Address) Rewers Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

V. S. NO. 2. 50M-9-19 I X16605

RECEIVED
District Health Officer No. 10
District File Number 9-44-~~14100~~ 15000
Date Filed SEP 5 1944

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~~ George William DE Jong Iowa License 3286, ~~Registered Apprentice No.~~, working under my personal supervision.

Signed G. W. DE Jong

Licensed Embalmer No. 3286 Iowa

P. O. Address Keokuk, Iowa

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.