

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 11 1844

Registration District No. 11

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5434

State File No.

27685

Registrar's No.

71

1. PLACE OF DEATH:

(a) County Franklin Co
(b) City or town Washington Mo R.R.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 RURAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME HENRY A. WEBBINK

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

4. Sex M 5. Color or race M 6. (a) Single, widowed, married, 2 divorced, Widowed

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

7. Birth date of deceased Jan. 1 1860 (Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 5 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business

MOTHER FATHER { 12. Name Albertus Webbink
13. Birthplace Holland (City, town, or county) (State or foreign country)
14. Maiden name Maria Huckerian
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature George Webbink

(b) Address Augusta Mo

17. (a) Buried (b) Date thereof Aug. 8-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ferne Edge Cemetery

18. (a) Signature of funeral director Thelma J. Muech

(b) Address Augusta Mo

19. (a) 8-7-44 (b) Franklin Brooks (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin
(c) City or town Washington Mo R.R. (If outside city or town limits, write "RURAL")
(d) Street No. — (If rural, give location)
(e) If foreign born, how long in U. S. A. 79 years years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 6 year 44 hour 7 minute 157 A.M.

21. I hereby certify that I attended the deceased from June 1944 to Aug 5, 1944

that I last saw him alive on Aug 5 and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiac decompensation Duration

Due to Chronic myocarditis

Due to 93d

Other conditions (Include pregnancy within 3 months of death)

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?

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

23. Signature A. P. M. M. D. (M. D. or other) Address Washington Mo Date signed 8/7/44

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 9-5-44.....

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 *M. Muschany* # 2461
O. Thiering # 3759

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.