

No. 2  
8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38901  
Registrar's No. 41

FILED SEP 13 1944

Registration District No. 2206 Primary Registration District No. 6108

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

1. PLACE OF DEATH:

(a) County Scotland

(b) City or town Greenburg Rural  
(If outside city or town limits, write "RURAL" and name of township)

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

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

In this community Entire Life  
years, months or days

3. (a) PRINT FULL NAME Mrs Eare M. Webster

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Eare M. Webster

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Sept 20 - 1892  
(Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 3

If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Knox Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name J. A. Lane

13. Birthplace Knox Co. Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Harriet Phillips

15. Birthplace Scotland Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Eare M. Webster

(b) Address Greenburg Mo

17. (a) Burial (b) Date thereof Aug 25 - 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Ridge East Park

18. (a) Signature of funeral director Memphis Mo

(b) Address \_\_\_\_\_

19. (a) Aug 31, 1944 (b) Bernice Nelson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scotland

(c) City or town Greenburg Rural  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23 year 1944 hour 9 minute 40 P.M.

21. I hereby certify that I attended the deceased from Oct 1 1944 to Aug 28 1944 that I last saw her alive on Aug 28 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia following carcinoma of the mammary gland

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 50  
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 \_\_\_\_\_

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 B. G. Linnell (M. D. or other)

Address Edina Mo Date signed Aug 24/44

RECEIVED

District Health Officer No. 10

District File Number 9-44-1581

Date Filed SEP 12 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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Fred Gerth

Licensed Embalmer No. 4256

P. O. Address Memphis

**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.

Registration District No. 226

Primary Registration District No. 6108

Registrar's No. X1

1. PLACE OF DEATH:

(a) County Scotland  
(b) City or town Rural John Jay  
(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 ALTA M. Salster

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Sept 20 1946  
(Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 20 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Bernice Wilson (Registrar's signature)  
(Date received local registrar) (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 Aug Day 3  
Year 1946 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

