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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 11 1944
Registration District No. 157

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 244

Primary Registration District No. 3028

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

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 1/2 hours
(Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper 49
(c) City or town Carthage, Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Route 3, Carthage
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - 0

3. (a) PRINT FULL NAME Perry Webster
3. (b) If veteran, name war No
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 13
year 1944 hour 4:45 minute A M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 7 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 12 1944 to Nov 13 1944
that I last saw him alive on Nov. 12 1944
and that death occurred on the date and hour stated above.
Immediate cause of death Uremic poison Duration _____

8. AGE: Years 69 Months 4 Days 6
If less than one day
hr. _____ min. _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____

9. Birthplace Mt. Rose Iowa
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business None

Underline the cause to which death should be charged statistically.

MOTHER FATHER {
12. Name George Webster
13. Birthplace unknown Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Cornelia M. Allen
15. Birthplace unknown New York
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Webster
(b) Address Detroit, Michigan
17. (a) Burial (b) Date thereof Nov. 16, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery

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? _____

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Missouri
19. (a) Nov. 16 '44 (b) Elizabeth Couplin
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature P. A. Webster (M. D. or _____)
Address Carthage, Mo. Date signed Nov. 13 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..... *Emm R Kneef*

Licensed Embalmer No. *391*

P. O. Address..... *Carthage*

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.

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Registration District No. 157 Primary Registration District No. 3028

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(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)

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 _____

3. (a) PRINT FULL NAME Perry Webster
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov Day 13 Year 1946 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above and the immediate cause of death chronic nephritis Duration _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Sept 7 (Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days _____ If less than one day, _____ min.

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

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

Due to Chronic nephritis

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations _____ Of autopsy _____

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 P. Webster (M. D. or other)

Address Carthage, Mo Date signed See 16

SUPPLEMENTARY

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

MOTHER FATHER

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

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