

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED JUN 13 1946 STANDARD CERTIFICATE OF DEATH

State File No. **17436**
Registrar's No. **86**

Registration District No. **218** Primary Registration District No. **5790**

1. PLACE OF DEATH:
(a) County **Mississippi, Wolf Island**
(b) City or town **East Prairie (Rural)**
(c) Name of hospital or institution: **Route 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **21 years**
In this community **21 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Mississippi**
(c) City or town **East Prairie (Rural)**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 1**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Edward Webb**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **14**
year **1946** hour **12** minute **30 A.** M.

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Rachel Webb**
6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **May 30, 1890**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **12-7-45** to **5-11-46**
that I last saw him alive on **5-11-46**
and that death occurred on the date and hour stated above.
Immediate cause of death **Hypertensive Heart Disease**

8. AGE: Years **55** Months **11** Days **16**
If less than one day hr. min.

Due to **Chronic Nephritis**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **MI**
Of autopsy _____

9. Birthplace **Potts Camp, Miss.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farming**
11. Industry or business **Farming**

Due to **Chronic Nephritis**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **MI**
Of autopsy _____

MOTHER FATHER
12. Name **Alec Webb**
13. Birthplace **(Unknown) Mississippi**
(City, town, or county) (State or foreign country)
14. Maiden name **Hannah** (Unknown)
15. Birthplace **(Unknown) Mississippi**
(City, town, or county) (State or foreign country)

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) (c) Means of injury _____

16. (a) Informant **Charles H. Webb**
(b) Address **R. 1, East Prairie, Mo.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **May 18, 1946**
(Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove 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?
While at work? _____ (Specify type of place) (c) Means of injury _____

18. (a) Signature of funeral director **F. J. Sparks**
(b) Address **Capo Girardeau, Mo.**
19. (a) **6-6-46** (Date received local registrar) **Bertrude Y. Harper** (Registrar's signature)

23. Signature **W. A. General** (M. D. or other) **W. A. General**
Address **204 S. Forest St. Charleston, Mo.** Date signed **5-22-46**

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

RECEIVED

District Health Office No. 2,

District File Number 6-16-73

Date Filed 6-12-46

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 Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cap. Siendean md.

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.