

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26682

FILED SEP 10 1946
82

Registration District No. 82

Primary Registration District No. 2017

Registrar's No. 233

1. PLACE OF DEATH:

(a) County Cooper
 (b) City or town Bonville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Ravenway Clinic
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 days
 In this community 14 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper
 (c) City or town Bonville
 (If outside city or town limits, write "RURAL")
 (d) Street No. 317 E. St. Louis
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME OPAL JENNE WEBB

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

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

6. (b) Name of husband or wife Dwight Webb 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Self

12. Name Joe Wilkey

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

14. Maiden name Lyla Steels

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

16. (a) Informant Mary Holder

(b) Address Sedalia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia Mo

18. (a) Signature of funeral director F. F. Ferguson

(b) Address Sedalia Mo

19. (a) 8-74-46 (Date received local registrar) (b) Clay Adams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 12 year 1946 hour 4:30 PM minute _____ M.

21. I hereby certify that I attended the deceased from aug 7 1946 to aug 12 1946
 that I last saw her alive on aug 12 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexia cerebri Duration _____
Hypertension

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations none

Of autopsy none

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 Allen Ravenway MD (M. D. or other)

Address Bonville Mo Date signed 8-14-46

WRITE PLAINLY - USE UNFADING INK FOR NAME & PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

7-7-46

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 *F. D. Ferguson*

Licensed Embalmer No. *2172*

P. O. Address *Marshall*

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. *82*

Primary Registration District No. *3017*

Registrar's No.

1. PLACE OF DEATH:

(a) County *Cooper*
(b) City or town *Boonville*
(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 *Opal J. Webb*

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

4. Sex *F* 5. Color or race *B* 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife *Wright* (c) Age of husband or wife if alive _____ years

7 Birth date of deceased *unknown* (Month) _____ (Day) _____ (Year) _____

8. AGE: Years *50* Months *5* Days _____ If less than one day _____ hr. _____ 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) *Aug 18 - 46* (b) *Clay Morris* (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 _____ Day _____ Year *1946* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him _____ alive on _____ 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)

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

2B
45
3880

266082