

No. 2  
8-43  
5-17-39  
K37823

FILED MAY 26 1947

Registration District No. 2074

Primary Registration District No. 2074

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Scott 100  
(b) City or town Sikeston, Mo. 5  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 233 Alabama St. Home 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Twenty nine years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott 100  
(c) City or town Sikeston 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. 233 Alabama Street 2  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Harold Webb

3. (b) If veteran, name war

no

3. (c) Social Security No.

\_\_\_\_\_

4. Sex

M

5. Color or race

C

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

M

6. (b) Name of husband or wife

Rosa Webb

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

59 years

7. Birth date of deceased

May (Month)

21 (Day)

1873 (Year)

8. AGE:

Years: 67 Months: 11 Days: 22  
If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace

Mississippi (City, town, or county)

\_\_\_\_\_ (State or foreign country)

10. Usual occupation

Farming

11. Industry or business

\_\_\_\_\_

12. Name

Charles Webb

13. Birthplace

Unknown (City, town, or county)

\_\_\_\_\_ (State or foreign country)

14. Maiden name

Josephine Webb

15. Birthplace

Unknown (City, town, or county)

\_\_\_\_\_ (State or foreign country)

16. (a) Informant

Rosa Webb

(b) Address

233 Alabama Street Sikeston

17. (a) Burial (Burial, cremation, or removal)

Burial

(b) Date thereof: 5-19-47 (Month) (Day) (Year)

(c) Place: burial or cremation

Sunset Cemetery

18. (a) Signature of funeral director

Fred J. Smith

(b) Address

1212 Maul St. Sikeston, Mo.

19. (a) Date received local registrar

5-18-47

(b) Mrs. J. E. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month

5 day

13

year 1947 hour 6:00 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from

4-11-1947 to

5-2-1947

\_\_\_\_\_ 1947

that I last saw him alive on 5-2-1947 and that death occurred on the date and hour stated above.

Immediate cause of death

Hypertensive Heart Disease & Right Hemiplegia

Duration

4 mono.

Due to

Chronic Nephritis

6 mono.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

\_\_\_\_\_ 1313

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)

(b) Means of injury \_\_\_\_\_

23. Signature

W. A. Lingal (M. D. or other)

Address 204 S. Locust St. Charleston, Mo. signed 5-17-47

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

6-11-47

RECEIVED  
District Health Office No. 77  
District File Number 542-730  
Date Filed 5-19-42

MAY 26 1942

JUN 11 1942

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 J. Smith*

Licensed Embalmer No. 4408

P.O. Address 1212 Maud St. S. Kenton

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. 223 Primary Registration District No. 3074

1. PLACE OF DEATH:  
(a) County Scott  
(b) City or town Selester  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Hamed Webb  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife Rose Webb 6. (c) Age of husband or wife if alive 58  
7. Birth date of deceased May 2, 1911  
(Month) (Day) (Year)

8. AGE: Years 64 Months 11 Days \_\_\_\_\_ (Unless less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Mus  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) 6-13-47 (b) Mr J F Henry  
(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 \_\_\_\_\_ Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M. 13  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

MOTHER FATHER

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

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

S-19849