

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43475**

FILED JAN 2 1951

BIRTH NO. _____ REG. DIST. NO. **375** PRIMARY REG. DIST. NO. **6283** Registrar's No. **47**

1. PLACE OF DEATH a. COUNTY WRIGHT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 1140	
b. CITY (If outside corporate limits, write RURAL and give township) ELK CREEK RURAL		c. CITY (If outside corporate limits, write RURAL and give township) RURAL Elk Creek	
c. LENGTH OF STAY (In this place) 63		d. STREET ADDRESS (If rural, give location) 4 mi South Competition	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED a. (First) Archie b. (Middle) Virgil c. (Last) Webb			4. DATE OF DEATH (Month) (Day) (Year) 12-19-1950		
5. SEX MO		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH 3-13-1887		9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months 9 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wright County	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Glover Webb		13b. MOTHER'S MAIDEN NAME Francis Davis		14. NAME OF HUSBAND OR WIFE MRS Mabel Webb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME MRS. Mabel Webb, Competition, Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) snitroide insufficiency		ANTECEDENT CAUSES			410X	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b)				
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **6:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE J. K. Lough		(Degree or title)		23b. ADDRESS Grave Springs, Mo		23c. DATE SIGNED 12-27-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 12-22-50		24c. NAME OF CEMETERY OR CREMATORY Claxton Cemetery		24d. LOCATION (City, town, or county) (State) Competition, Mo	
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DATE REC'D BY LOCAL REG. Dec. 29, 1950		REGISTRAR'S SIGNATURE E. Garner		25. FUNERAL DIRECTOR'S SIGNATURE Gene C. Zalden		ADDRESS Fortville, Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1140

WRIGHT CO. HEALTH DEPT.
County File Number 250-144
Date Filed Dec. 20, 1950

RECEIVED
JAN 9 1951

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Gene E. Aldred

Licensed Embalmer No. 3865

P. O. Address Hartsville, Mo

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.