MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

955

1. PLACE OF DEATH
County Howell — Registration District No. 383
Township ~~Goldsberry~~ — Primary Registration District No. 5296
City Mountain View Mo. — St. — Ward)

File No.
Registered No. 22

2. FULL NAME John H Webster
(a) Residence. No. — St., — Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred — yrs. 15 mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(or) WIFE OF~~ Laura Webster

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't Know

7. AGE: 75 Years — Months — Days — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT L. R. Holden
(Address) Mountain View Mo

15. FILED 1-12-1930 G F Gose
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1930, to Jan 12 1930 that I last saw him alive on Jan 9th 1930, and that death occurred, on the date stated above, at 11 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess of ear &
Pneumonia of Lungs
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 108
(duration) 89 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No DATE OF ✓
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical
(Signed) [illegible], M. D
, 19 (Address) Mtn View Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Chappell Hill — DATE OF BURIAL: Jan 14 1930

20. UNDERTAKER: John F Duncan — ADDRESS: Mt View Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.— Every item of information should be carefully supplied. AGE should be given in years, months and days. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of Cancer and Tumor is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1. PLACE OF DEATH.
County: Howell — Registration District No.: 383 — File No.:
Township: — Primary Registration District No.: 3226 — Registered No.: 22
City: Mtn View (No. ..... St. ..... Ward)

2. FULL NAME: John H. Webster

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Div.

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 1-12 30, 19 G. F. Lee
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess of ear and Pneumonia of lungs
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Local
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? None
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY