

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

1939 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 1939 OCT 16 1939

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 33487
 Registrar's No. 1710

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town City Koch ~~Town Escondido~~
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Koch Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 mos 24 days
16 years (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2315 Hickory
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Webb, William 10th
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month September day 27
 year 1939 hour 7 minute 45 P.M.
 21. I hereby certify that I attended the deceased from 6-3
 _____, 1929, to 9-27, 1939;
 that I last saw h. live on 9-26, 1939
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mrs. Maggie Webb
 6. (c) Age of husband or wife if alive 53 years
 7. Birth date of deceased 4 4 1885
 (Month) (Day) (Year)

Immediate cause of death _____
 Due to Pulmonary Tuberculosis
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

8. AGE: Years 54 Months 5 Days 23
 If less than one day _____ hr. _____ min.

Major findings:
 Of operations _____
 Of autopsy Pulmonary Tuberculosis & acc-
-cary I.B. of larynx & Trachea

9. Birthplace Libertyville Mo.
 (City, town, or county) (State or foreign country)
 10. Usual occupation Laborer

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? _____

11. Industry or business _____
 12. Name John Webb
 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Albertine Counsel
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Koch Hospital
 (b) Address Koch, Mo
 17. (a) Burial (b) Date thereof 9/29/39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Matthews Cem

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature William Stambaugh (M. D. or other)
 Address Koch Hospital, Koch Mo Date signed 9/28/39

18. (a) Signature of funeral director W. H. McLaughlin
 (b) Address 2301 Lafayette Ave
 19. (a) SEP 29 1939 (b) W. R. Meyer
 (Date received local registrar) (Registrar's signature)

Rev. 5-17-39 I 19391

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

L. V. Cooper

Licensed Embalmer No.

3633

P. O. Address

2317 Palmyra

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, above space should be left blank.