

FD JAN 13 1941

Registration District No. 213

Primary Registration District No. 3014

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

1. PLACE OF DEATH

(a) County Cole
(b) City or town Jefferson City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1027 East Atchison St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

3. (a) PRINT FULL NAME TAYLOR WEBB

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

4. Sex Male 5. Color or race negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 3 1940
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 5 If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Frankie Graham
(b) Address 1037 E. Atchison

17. (a) Burial (b) Date thereof Dec 10 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Louquiers Cemetery

18. (a) Signature of funeral director Louquiers Cemetery
(b) Address 700 Jefferson St.

19. (a) 12-19-40 (b) D. B. Spofford
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cole
(c) City or town Jefferson City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 1027 E. Atchison
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8
year 1940 hour 6 am minute _____ M.

21. I hereby certify that I attended the deceased from 12/5/40, 19____, to 12/8/40, 19____;
that I last saw him alive on 12/7/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Arterio Sclerosis

Due to _____

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

Major findings: None
Of operations _____

Of autopsy _____

Duration

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 D. B. Spofford (M. D. or other) _____
Address Jefferson City, Mo Date signed 12/12/40

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.

Signature

J. N. Anderson

Licensed Embalmer No.....

3641

P. O. Address.....

Jefferson Co

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42230

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson
(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 Taylor Webb

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

4. Sex m 5. Color or race negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Darsh Webb 6. (c) Age of husband, or wife, if alive 80 years

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

8. AGE: Years 84 Months _____ Days 5 If less than one day _____ hr. _____ min.

9. Birthplace (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. (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/14/40 (b) [Signature] (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) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month Dec day 8 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ 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 [Signature] (M. D. or other) _____
Address Jefferson City Date signed _____

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

SUPPLEMENTAL

1940

S-42230