

FILED OCT 15 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 100

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether
In this community 56 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Howell (b) County Missouri
(c) City or town Mountain View, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. rural
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Albert H. Webb

3. (b) If veteran, name war. No

3. (c) Social Security No. No

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 27th 1889
(Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Howell Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name John D. Webb
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Neffana Borren
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Sam Webb
(b) Address Mountain view, Mo

17. (a) Burial (b) Date of death Sept 20th 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chappell Hill Cem.

18. (a) Signature of funeral director: John D. Mean

(b) Address Mountain view, Mo

19. (a) SEPT. 20, 1945 (b) Gladys Harrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17th
year 1945 hour 4 minute _____ a.m.

21. I hereby certify that I attended the deceased from Sept. 15, 1945 to Sept. 17, 1945
that I last saw him alive on Sept. 15, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pertitonitis, acute Duration 36 h

Due to Appendicitis, acute intestinal obstruction

Due to _____

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

Major findings: Of operations _____

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) no
(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 A. H. Thompson (M. D. or other) 9/19/45
Address West Plains, Mo. Date signed _____

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

RECEIVED

District Health Officer No. 5

District File Number 1045512

Date Filed 10.13.45

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 John J. Duncan

Licensed Embalmer No. 2516

P. O. Address Mountain View, 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.