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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR Hope
2328
State File No. _____

FILED JAN 21 1946

Registration District No. _____ Primary Registration District No. 5180

Registrar's No. _____

1. PLACE OF DEATH:

(a) County CAMDEN

(b) City or town DECAUTERVILLE
(If outside city or town limits, write "RURAL" and name of township) Warren

(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 ALWAYS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County CAMDEN / 5

(c) City or town DECAUTERVILLE / 0
(If outside city or town limits, write "RURAL") / 0

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME RETA JEAN WEBSTER

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

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased SEPT 7 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

1	3	23	hr.	min.
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9. Birthplace CAMDEN Co MO / h
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name WILLIE WEBSTER

13. Birthplace CAMDEN Co MO / U
(City, town, or county) (State or foreign country)

14. Maiden name DELLA Nichols

15. Birthplace ARK / 1
(City, town, or county) (State or foreign country)

16. (a) Informant Della Webster
(b) Address DECAUTERVILLE MO

17. (a) BURIAL (b) Date thereof 12-31-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PLEASANT HILL

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO

19. (a) Jan-27-46 (b) Zilpha J. Iron
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 30
year 1945 hour 8 minutes 30 A. M.

21. I hereby certify that I attended the deceased from 12/15
1945 to 12/30 1945
that I last saw her alive on 12/25 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Tuberculous Pneumonia / 5 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 13h

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 James A. Hope (M. D. or other)
Address Lebanon, Mo Date signed 1/4/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

W. Palmer

Licensed Embalmer No. *1161*

P. O. Address *Lebanon 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 727
Registrar's No. 3

Registration District No. 50 Primary Registration District No. 5180

1. PLACE OF DEATH:
(a) County Camden
(b) City or town Decaturville Warren Twp
(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 Reta J. Webster
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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) Jan 27-1946 (b) Zelpha Isaac
(c) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I had seen _____ 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)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____ (M. D. or other)
Address _____ Date signed _____

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

100083

SUPPLEMENTARY

2328