DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 22003

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 226

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Bonne Terre, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community 9 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Washington
(c) City or town Irondale
(If outside city or town limits, write "RURAL")
(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 Alice Lucille Webster
3. (b) If veteran, name war
3. (c) Social Security No. 506-10-0613

4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife William L. Webster
6. (c) Age of husband or wife if alive 23 years
7. Birth date of deceased 1 (Month) 15 (Day) 1912 (Year)

8. AGE: Years 35 Months 5 Days 8 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Nebraska (State or foreign country)
10. Usual occupation housewife
11. Industry or business none

MOTHER FATHER
12. Name Harry Schlund
13. Birthplace Unknown (City, town, or county) Nebraska (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Nebraska (State or foreign country)

16. (a) Informant William Webster
(b) Address Irondale, Missouri
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6 - 25 - 47 (Month) (Day) (Year)
(c) Place: burial or cremation Hopewell
18. (a) Signature of funeral director Bert L. Boyer
(b) Address Leadwood, Missouri
19. (a) 7-5-47 (Date received local registrar) (b) Esther Rudolph (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23 year 1947 hour 9 minute A.M.

21. I hereby certify that I attended the deceased from 6-16, 1947, to 6-23, 1947; that I last saw her alive on 6-23, 1947; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Intestinal Obstruction | 10 da. |
| Due to: Adhesions following appendectomy | ? |
| Due to: — | |
| Other conditions (Include pregnancy within 3 months of death): 122B | |

Major findings: Of operations: Adhesion band occluding terminal ileum.
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)
(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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Wm W Taylor M.D. (M. D. or other)
Address Bonne Terre, Mo. Date signed 6-24-47

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 242-964

Date Filed 7-9-42

JUL 11 1947

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 Bert L. Boyer

Licensed Embalmer No. 3446

P. O. Address Leadwood Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

2B
-45
43880

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

DEPARTMENT OF COMMERCE
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# STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 226

**1. PLACE OF DEATH:**

(a) County St Francois

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

(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 years, months or days)

In this community

**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

3. (a) PRINT FULL NAME Alice L 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 10 (Month) (Day) (Year)

8. AGE: Years 35 Months 5 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-5-47 (Date received local registrar) (b) Esther Rudolph (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July 23 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| 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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-22003