

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED DEC 27 1949

State File No. **42201**

BIRTH NO. **124** REG. DIST. NO. **316** PRIMARY REG. DIST. NO. **3061** Registrar's No. **441**

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, write RURAL and give township) Flat River	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Flat River	94
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 315 Division	

3. NAME OF DECEASED (Type or Print), a. (First) Charles	b. (Middle)	c. (Last) W.E.B.B.	4. DATE OF DEATH (Month) (Day) (Year) Dec. 13, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 6, 1877	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 7 Days 7	IF UNDER 1 HRS. Hours 7 Min.
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10a. USUAL OCCUPATION (Give kind of work done during present working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Owen Webb	13b. MOTHER'S MAIDEN NAME Amey Pipe	14. NAME OF HUSBAND OR WIFE Mary Webb
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no.	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Owen Webb	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4-10 H.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral Stenosis		
	ANTECEDENT CAUSES DUE TO (b) Don't Know Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none			

19a. DATE OF OPERATION X	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-13, 1949**, to **12-13, 1949**, that I last saw the deceased alive on **12-1, 1949**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) O.B. Laman M.D.	23b. ADDRESS Flat River, Mo.	23c. DATE SIGNED 12-13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 16, 1949	24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Embury	24d. LOCATION (City, town, or county) (State) Resmark, Mo.
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DATE REC'D BY LOCAL REG. Dec. 14, 1949	REGISTRAR'S SIGNATURE Esther Rudolph	25. FUNERAL DIRECTOR'S SIGNATURE Raymond Caldwell	ADDRESS Flat River, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

12-19-49
Health Officer No. _____
File Number 1249

Date filed _____

MAY 23 1962

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *R. Caldwell*

Licensed Embalmer No. *2531*

P. O. Address *Flat River, Mo.*

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

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