

Health,  
& Welfare  
S. Public  
th Service

S. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

FILED OCT 6 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031934

STATE FILE NUMBER

XC-570215

REG.# 17073

Registration District No. 43

Primary Registration District No. \_\_\_\_\_

Registrar's No. 574

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BUTLER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>POPLAR BLUFF</b> 0124 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>		Length of stay in lb <b>65 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>1203 NORTH TENTH ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY JAMES WEBB</b>			4. DATE OF DEATH Month Day Year <b>SEPTEMBER 6, 1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-93</b>
9. AGE (In years last birthday) <b>65</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (City and state or country) <b>POPLAR BLUFF, MO.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>JAMES H. WEBB</b>	13b. MOTHER'S MAIDEN NAME <b>MARY ANN PORTER</b>
14. NAME OF HUSBAND OR WIFE <b>NONE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WWI</b>	16. SOCIAL SECURITY NO. <b>497100471</b>
17. INFORMANT <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Week.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. Attended the deceased from <b>Sept. 1, 1958</b> to <b>Sept. 6, 1958</b> Death occurred at <b>12:35 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert S. Cohen, M.D., Chief, Medical Svc. VA HOSPITAL, POPLAR BLUFF, MO.</b>		22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>	22c. DATE SIGNED <b>9/8/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-7-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Poplar Bluff, Mo.</b>
24. FUNERAL DIRECTOR <b>Frank-Cotrell Poplar Bluff, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9/27/58</b>	26. REGISTRAR'S SIGNATURE <i>R. R. ...</i>

RECEIVED

OCT 3 1958

BUTLER CO. HEALTH CENTER

FILE No.

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 .....

Signature of Student Embalmer

Signed

Charles E. Mungl

Licensed Embalmer No.

4877

P. O. Address

Poplar Bl

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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