Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-023803
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 324 Primary Registration District No. 4475 Registrar's No. 1021

1. PLACE OF DEATH a. COUNTY Saline b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Malta Bend — Inside Limits Yes X No ☐ c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Street not no. — Length of stay in Hospital 13 yrs.	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline c. CITY OR TOWN Malta Bend — Inside Limits Yes X No ☐ d. STREET ADDRESS (If outside, give location) Streets not number — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First MILTON Middle Last WEBSTER				4. DATE OF DEATH Month June Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Oct. 3, 1881	9. AGE (In years last birthday) 78	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) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Camden County Mo	12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME W.H. Webster	13b. MOTHER'S MAIDEN NAME Elizabeth Garrison	14. NAME OF HUSBAND OR WIFE Mrs. Ida Webster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Paul Webster Address Malta Bend Mo.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 5 Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from May 29-59, to June 18-59 and last saw ~~her~~ him alive on June 18-59
Death occurred at 4:03 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Geo F. Jones M.D. (Degree or title)	22b. ADDRESS Waverly	22c. DATE SIGNED 6-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-20-1959	23c. NAME OF CEMETERY OR CREMATORY Blair Cemetery	23d. LOCATION (City, town, or county) (State) Camden County, Missouri
24. FUNERAL DIRECTOR Reed Funeral Home, Camdenton	ADDRESS	25. DATE RECD. BY LOCAL REG. 6-20-59	26. REGISTRAR'S SIGNATURE Cecil G. Read

(Licensed Embalmer's Statement on Reverse Side)

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.

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 Jack W. Reser

Licensed Embalmer No. 4643

P. O. Address Marshall

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.