

Registration District No. 236

Primary Registration District No. 6120

Registrar's No.

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Bartlett
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no (Specify whether years, months or days)
In this community 68 years

3. (a) PRINT FULL NAME James Layton Webb

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

4. Sex M 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 Nov 8 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 5 12 hr. min.

9. Birthplace Renolds Co Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Sidney A. Webb

13. Birthplace Kent
(City, town, or county) (State or foreign country)

14. Maiden name Julia F. Webb

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Jess Webb

(b) Address Bartlett, Mo.

17. (a) Burial (b) Date thereof 4-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Birch Tree Cemetery

18. (a) Signature of funeral director Joe K. Simeon

(b) Address Mountain view, Mo.

19. (a) 5-20-47 (b) Maebel Reelers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Shannon
(c) City or town Bartlett
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20 year 1947 hour 9 minute 30 a. m.

21. I hereby certify that I attended the deceased from Jan. 5 1947 to April 20 1947
that I last saw him alive on April 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death No Diagnosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 2004

Of autopsy _____

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 R. J. Davis (M. D. or other) 0
Address Birch Tree Mo Date signed 5/10/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 641316

Date Filed 6-17-47

OCT 2 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 Joe B. Durnan

Licensed Embalmer No. 4325

P. O. Address Mt. View, Md.

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.