

FILED SEP 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33425

Registration District No. 336

Primary Registration District No. 6130

Registrar's No.

1. PLACE OF DEATH:

(a) County ~~DE~~ SHANNON
(b) City or town RURAL
(If outside city or town limits, write "RURAL" and name of township)
(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.
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County SHANNON
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR ROUND SPRINGS,
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME ELMO WEBBER

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced. 50

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

7. Birth date of deceased. FEB 1 1929
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 7 7 hr. min.

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

10. Usual occupation. FARMER

11. Industry or business

12. Name BEN WEBBER

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

14. Maiden name MARY LIGHT

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

16. (a) Informant Ben Webber

(b) Address ROUND SPRINGS,

17. (a) DURNIAL (b) Date thereof 9-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SMITH BEM

18. (a) Signature of funeral director Carl X. Spencer

(b) Address Salem Mo.

19. (a) 9-20-47 (b) Mobile Peeler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 8
year 1947 hour 1:00 minute A.M.

21. I hereby certify that I attended the deceased from 9-6-1947 to 9-8-1947
that I last saw him alive on 9-8-1947
and that death occurred on the date and hour stated above.

Immediate cause of death

Corporation of Bowles
Due to Typhoid fever

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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?

(Specify type of place) While at work? (e) Means of injury

23. Signature Mark Hyde (M. D. or other)

Address Cummer Date signed 9-10-47

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, ~~by~~.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Wm. W. McDonald

Licensed Embalmer No.....

P. O. Address.....

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.