WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Morgan

Township ~~Moreau~~

or Village

or City Versailles (NO. ____ St.; ____ Ward)

Registration District No. 598 File No. 20351

Primary Registration District No. 4355 Registered No. 22

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jennie Woods

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE black

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH About (Month) (Day), 1863 (Year)

AGE about 50 yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Wife of Serry Woods.
(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper, 4-0

BIRTHPLACE (City or town, State or foreign country) Versailles, Missouri.

PARENTS

NAME OF FATHER Sam. McClanahan.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Versailles. Mo.

MAIDEN NAME OF MOTHER Elsie Livingston.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Morgan Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jerry Woods

(ADDRESS) Versailles, Missouri

Filed June 21, 1913 H N Lueman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 15 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from about April 20th, 1913, to about May 10th, 1913, that I last saw her alive on about May 10th, 1913; and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23A

(Duration) don't know yrs. ____ mos. ____ ds.

Contributory (SECONDARY) none

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.

June 21st 1913 (Address) Versailles, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Versailles Mo

DATE OF BURIAL May 16, 1913

UNDERTAKER E. Nelson

ADDRESS Versailles

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... , 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ..... , 191..... , to ..... , 191..... ,

that I last saw h..... alive on ..... , 191..... ,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

..... , 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... , 191.....
UNDERTAKER	ADDRESS