

WHILE FLAINLY, 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 Bullinger
Township White Water
or
Village
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 70

File No. 28993

Primary Registration District No. 3709

Registered No. 14

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

FULL NAME

George M Woodbridge

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Jan 20, 1856</u> (Month) (Day) (Year)		
AGE <u>57 yrs. 8 mos. 4 ds.</u>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>T. D. V.</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		
PARENTS	NAME OF FATHER <u>Marshall Woodbridge</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Texas</u>	
	MAIDEN NAME OF MOTHER <u>Elizabeth Ward</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Texas</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 6, 1919
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1st, 1912, to Sept 6th, 1919, that I last saw him alive on Sept 6, 1919, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Chronic Starvation of Stomach and bowels
170 B
118 C (Duration) 1 yrs. 4 mos. ds.

Contributory Not known
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) P. H. H. H. H. M. D.
Sept 6, 1919 (Address) Sidgwickville 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos F. Smith

(ADDRESS) Sidgwickville Mo

Filed Sept 7, 1919 P. H. H. H. H.

REGISTRAR

PLACE OF BURIAL OR REMOVAL Sidgwickville Mo DATE OF BURIAL Sept 7, 1919

UNBERTAKER St. W. Bullinger ADDRESS Sidgwickville

