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: Adair

Township or Village or City: Kirksville (NO. A.S.O. Hospital St.; Ward)

Registration District No. 4 — File No. 7275

Primary Registration District No. 3001 — Registered No. 169

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

FULL NAME: Samuel Gregory Wood

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Feb 4th (Month) (Day), 1872 (Year)

AGE: 42 yrs. mos. 24 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Cement

BIRTHPLACE (City or town, State or foreign country): Livingston Jct. Mo

PARENTS
- NAME OF FATHER: A. Wood
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia
- MAIDEN NAME OF MOTHER: Theba Nolan
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan J. Wood

(ADDRESS) Kirksville Mo

Filed Mch 3, 1914 — A. W. Parrish, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 28 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 21, 1914 to Feb 28, 1914, that I last saw him alive on Feb 28th, 1914, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Traumatic Meningitis accidental Struck with lever moving a house

1943 (Duration) One week yrs. mos. ds.

Contributory (SECONDARY): Skull fracture

(Duration) One yrs. Seven 7 ds.

(Signed) E. S. Lemon M. D.

3/3, 1914 (Address) Kirksville 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): 3 das

At place of death ___ yrs. ___ mos. 3 ds. In the State 15 yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? in Kirksville Mo

Former or usual residence: Kirksville Mo

PLACE OF BURIAL OR REMOVAL: Forest Park Cemetery

DATE OF BURIAL: Mar 3, 1914

UNDERTAKER: H. C. Wilson

ADDRESS: Kirksville

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.....

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