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.

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

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

PLACE OF DEATH

County Pulaski

Township Rambouillet Registration District No. 715 File No. 2967

or

Village Primary Registration District No. 5944 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 Robert Worden Woody

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	married

DATE OF BIRTH: January 16 (Month) (Day) 1840 (Year)

AGE: Seventy Five yrs. 9 mos. 16 ds. | If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Laclede County

PARENTS

NAME OF FATHER: Marsh Woody

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

MAIDEN NAME OF MOTHER: Margret Adams

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Cook

(ADDRESS) Cookville

Filed 1-15, 1916. R E Hoskins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct The 26 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from July 5, 1915, to Aug 9, 1915, that I last saw him alive on Aug 9, 1915, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

1 Pernicious Anemia

2

3

4

(Duration) 1 yrs. 10 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) L W Hartley M. D.

Dec 31, 1915 (Address) Nebo 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	DATE OF BURIAL
Mastodonia	Oct The 27, 1915
UNDERTAKER	**ADDRESS**
Scott Nicks	Brownfield

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIS
CERTIFICATE OF DEATH

Revised United States Standard 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 hospit give i of str

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

_____ (Month) (

I HEREBY CERTIFY, that I attended d

_____, 191___, to _____

that I last saw h_____ alive on _____

and that death occurred, on the date stated above,

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ m

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ m

(Signed) _____

_____, 191___ (Address) _____

*State the Disease Causing Death, or, in deaths from Viol (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicid

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

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF
UNDERTAKER	**ADDRESS**