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

5240

1 PLACE OF DEATH

County Dade

Township ~~[illegible]~~ Registration District No. [illegible] File No.

or

Village Primary Registration District No. [illegible] Registered No.

or

City ~~[illegible]~~ Greenfield (NO. St.; Ward)

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

2 FULL NAME [illegible] Wood [illegible]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Feb (Month) 14 (Day) 1853 (Year)

7 AGE: 66 yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Marion Ill

PARENTS

10 NAME OF FATHER: David Wood

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

12 MAIDEN NAME OF MOTHER: Dom Knox

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dom Knox

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible] Edwards

(Address) Greenfield Mo

15 Filed Jan 12, 1919 Hugh Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 12 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 4, 1919, to Jan 10, 1919, that I last saw him alive on Jan 10, 1919, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Influenza. (Brain Complication)

118 10 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

9 (Duration) yrs. 1½ mos. ds.

(Signed) G. L. Weir M. D.

Feb 13, 1919 (Address) Greenfield Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Greenfield Tenn

DATE OF BURIAL: Jan 3, 1919

20 UNDERTAKER: Hugh Harrison

ADDRESS: [illegible]

LOCAL REGISTRAR'S RECORD—DO NOT TEAR [illegible]

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... , Registered No. .....
or
City ..... (NO. ..... , ... St.; ..... Ward) [illegible]

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

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

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

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... , 191..... , ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
..... , 191.....

20 UNDERTAKER

ADDRESS

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

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