

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

Do not use this space.

5106

1. PLACE OF DEATH
 County Stoddard Registration District No. 840
 Township Duane Creek Primary Registration District No. L102
 City..... (No.....)..... St. Ward)
 2. FULL NAME J. D. Wood
 (a) Residence. No..... St..... Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (specify the word) married
 5A. In Marriage, Widowed, or Divorced HUSBAND OF (OR) WIFE OF Mada Wood
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-1-1848
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 2 4
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gibson Co. Indiana
 10. NAME OF FATHER Abner Wood
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 12. MAIDEN NAME OF MOTHER Emmelia Ashley
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana

14. INFORMANT Mada Wood (Address) Puxico R # 1
 15. FILE Jan 6, 1929 E L Hope REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-5 1929
 17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1928, to Jan 6 1929, and that I last saw him alive on Dec 29 1928, and that death occurred, on the date stated above, at 11:15 a.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Failure Heart & Lungs
11B
92.2 (duration) yrs. 1 mos. da.
 CONTRIBUTORY (SECONDARY) 90A (duration) yrs. mos. da.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?
 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) E L Hope M. D.
1/6 1929 (Address) Puxico Mo
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hill Cemetery DATE OF BURIAL 1-6 1929
 20. UNDERTAKER J. A. Child ADDRESS Bloomfield

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

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W. D. ...
... ..

MAY 8 1967

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

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Stoddard
Township Duck Creek
City..... (No.....)

Registration District No. 840
Primary Registration District No. 6102

File No.
Registered No. 6
St. Ward)

2. FULL NAME

F. D. Wood

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-1-1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>60</u>	<u>2</u>	<u>4</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED Jan 1, 1929 Ed Hope
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 - 1929

17.

I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. D.
. 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AG. should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of C.C. at time of death is important. REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES. THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-5106