

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

Do not use this space.

13450

PLACE OF DEATH

County Saline
Township Slater
City Slater (No. _____ St. _____ Ward _____)

Registration District No. 799
Primary Registration District No. H479

File No. _____
Registered No. 18

2. FULL NAME

Erma May Lee Woods (col)
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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 Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-17-26

7. AGE: YEARS MONTHS DAYS IF LESS than 1 day, _____ bra. or _____ min.
2 6 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER John Woods

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

12. MAIDEN NAME OF MOTHER Sophia Frisbie

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

14. INFORMANT Sophia Woods
(Address) Slater Mo

15. FILE 3 15 29 W. M. Still
19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 12 19 29

17. I HEREBY CERTIFY, That I attended deceased from 3-1-29 to 3-8-29, 19____, that I last saw her alive on 3-8-29, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
IB

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____
8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. M. Still, M. D.
, 19 _____ (Address) Slater 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 Slater Colored Cemetery DATE OF BURIAL March 14 29

20. UNDERTAKER Jones & Sager ADDRESS Slater Mo

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.

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1928

