

THIS IS A PERMANENT RECORD

MAY 29 1929

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

Do not use this space.

15657

1. PLACE OF DEATH

County Call
Township Call
City Call (No. _____)

Registration District No. 727
Primary Registration District No. 5-959

File No. 91
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ira Marie Woods

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. _____ mos. _____ ds. 17 How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Clara B. Woods

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

3/18/1901

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>28</u>	<u>-</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife
(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) Call Co. Mo.

10. NAME OF FATHER

Henry M. Webb

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Call Co. Mo.

12. MAIDEN NAME OF MOTHER

Anna M. Tison

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Call Co. Mo.

14.

INFORMANT Henry M. Webb
(Address) Perry Mo.

15.

FILED 4/5-29 Herb Roelle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

4/5-1929

17.

I HEREBY CERTIFY, That I attended deceased from 3-29-1929, to 4-5-1929, that I last saw her alive on 4-4-1929, and that death occurred, on the date stated above, at 7-30 A.M.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

145 childbirth, followed
with septic conditions
98 but no fever.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Organic heart dis.
(Enlarged) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Resuter, M. D.

(Address) Perry 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

DATE OF BURIAL

Fern Chapel Mo 4/7-1929

20. UNDERTAKER

ADDRESS

Herb Roelle Perry Mo.

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.

