

JUL 25 1929

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

Do not use this space.

17934

1. PLACE OF DEATH

County Howard  
Towship St. Louis  
City Glasgow (No. .... St. .... Ward)

Registration District No. 379  
Primary Registration District No. 4223

File No. ....  
Registered No. ....

2. FULL NAME

Clora Woods

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

Length of residence in city or town where death occurred 44 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? 44 yrs. 0 mos. 0 ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Black 5. ~~Single~~ MARRIED, Widowed or Divorced (write the word) married

5A. ~~Is~~ MARRIED, Widowed, or Divorced  
HUSBAND or (or) WIFE of William Woods

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-29-1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
44 0 0

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) Howard  
(STATE OR COUNTRY) County MO

10. NAME OF FATHER J. E. Casin

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

12. MAIDEN NAME OF MOTHER Mrs. Brown

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

14. INFORMANT William Woods  
(Address) Glasgow MO.

15. FILED 6/30-29 Ch. Temple  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-24 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 9:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Angina Pectoris  
94B (Death Sudden)  
(duration) 1 yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) 89  
(duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRIBUTED  
IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chemical  
(Signed) Ch. Temple, M. D.

9/30, 1929 (Address) Glasgow 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 Lincoln Cemetery DATE OF BURIAL June 1929

20. UNDERTAKER Jerry Walker ADDRESS Glasgow 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.

THIS IS A PERMANENT RECORD

