

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

Do not use this space.

18475

PLACE OF DEATH

County Jackson
Township Pravies
City Lee's Summit (No. _____)

Registration District No. 400
Primary Registration District No. 472 P 5

File No. _____
Registered No. 67
St. _____ Ward _____

2. FULL NAME

Malvina M. Woodson

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

Length of residence in city or town where death occurred 40 yrs. - mos. - ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-10-1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
81 11 26

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Raytown
(STATE OR COUNTRY) Jackson Co. Mo.

10. NAME OF FATHER Gion Flansburg

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

12. MAIDEN NAME OF MOTHER unknowon

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

14. INFORMANT Jesse Gavin
(Address) Lee's Summit Mo.

FILED 7 1929 W. H. James REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-6 1929

17. I HEREBY CERTIFY, That I attended deceased from _____
Pravies, 1928, to May 6, 1929
that I last saw her alive on May 6, 1929, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aciculla Fibillata
66 B
95 B (duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) Typhoid Adenoma (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Spain

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Spiz's findings
(Signed) Wenard C. Allen, M. D.
6-12-29 (Address) 8W 3rd Lee's Summit 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 Besonica Cemetery DATE OF BURIAL 7-8 1929

20. UNDERTAKER W. C. Fields Lee's Sum ADDRESS mit Mo.

RECORDING INK--THIS IS A PERMANENT RECORD
Fully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 400 File No. _____
Township _____ Primary Registration District No. 4235 Registered No. 67
City Jackson (No. _____) St. _____ Ward _____

2. FULL NAME

Malvina M. Woodson
(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 F 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)

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

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

1929

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-6-1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) Toxic Adenoma of Thyroid (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) W. B. Harris, M. D.

, 19 _____ (Address) 812 1/2 E. 12th St. Jackson, 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

20. UNDERTAKER

ADDRESS

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. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOT RECEIVE A CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-18475