

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.

10.

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

Do not use this space.

23802

AUG 22 1929

1. PLACE OF DEATH  
 County Boone, CO Registration District No. 74  
 Township Boone Primary Registration District No. 3118  
 City (No. ....) St. .... Ward)

2. FULL NAME Ida Mary 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.

File No. 8  
 Registered No. 8

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 Mr. J. Woodson  
June 23, 1857

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	72	0	27	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) House Wife  
 (c) Name of employer

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

PARENTS

10. NAME OF FATHER Matthew Baumgartner  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Mary Calman  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany  
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Paul Vauldrol  
 (Address) Boonville, Mo.

15. FILED 7-25, 1929 Mrs. F. L. Fauver  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-12-1929

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 17, 1929 that I last saw her alive on July 17, 1929 and that death occurred, on the date stated above, 11-30 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Malarial Fever. Remittent

1864  
1928  
 (duration) yrs. mos. 7 ds.

CONTRIBUTORY Fractured Hip  
 (SECONDARY) (duration) yrs. 4 mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY? 0

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) O. B. Lawrence M. D.  
July 8, 1929 (Address) Hallerville 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 Kuller's Burial Home Co. DATE OF BURIAL July 19 1929

20. UNDERTAKER Low McHard ADDRESS Boonville

2330

29

110

100

100

100

100

100

100

100

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 Boone  
Township Pucky Fork  
City (No. .... St. .... Ward)

Registration District No. 44  
Primary Registration District No. 9-113

File No. ....  
Registered No. 8

2. FULL NAME

Ira Mary Woodson

(a) Residence, No. .... St. .... Ward. (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  
(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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-17 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:

Malignant fever  
Peritonitis  
Fractured Hip  
Septic  
(duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY) Septic (duration) ..... yrs. 4 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? 12  
(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  
20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

15c FILED 7-25-29 Mrs. L. J. Juncos REGISTRAR

S-23802