

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

AUG 23 1929

1. PLACE OF DEATH

County Darwin Registration District No. 250
Township..... Primary Registration District No. 4150
City Gallatin (No.) St. Ward)

File No.
Registered No. 542

2. FULL NAME

Frank A. Woodruff

(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 Male 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 Sarah M. Woodruff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 3-1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 | 7 | 4 |

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

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

10. NAME OF FATHER Geo. Woodruff

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

12. MAIDEN NAME OF MOTHER Paulina Fisher

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

14. INFORMANT Frankie W. Tolbert (Address) Gallatin Mo.

15. FILED 7-13-29 Ph. Lindner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July-11-1929

17. I HEREBY CERTIFY, That I attended deceased from Jan-22-1928, to July-11-1929, that I last saw him alive on July 11-1929, and that death occurred, on the date stated above, at 5:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pericucious Aneurisma

11A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) SSW (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) R.P. Doolin, M.D.
7-13-1929 (Address) Gallatin, 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 Brown DATE OF BURIAL 7/14-1929

20. UNDERTAKER H. Hoffe ADDRESS Gallatin 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.

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WRITE PROMPTLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

