

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

Do not use this space.

Babbling
81563

PLACE OF DEATH

County *Pitts*
Township *Spring Creek*
City *Sulphur* (No. *152*)

Registration District No. *668*
Primary Registration District No. *5591*

File No. _____
Registered No. *283*
St. _____ Ward _____

2. FULL NAME

Soren Arnet Woods

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 27, 1883*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 3 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Farmer*
(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) *mo*

10. NAME OF FATHER *Randolph Woods*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*

12. MAIDEN NAME OF MOTHER *Mary Montgomery*

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

14. INFORMANT *Mrs L A Woods*
(Address) *Sedalia mo*

15. FILED *CH 19 29* REGISTRAR *J J Love*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 29 1929*

17. I HEREBY CERTIFY, That *13* years, called to *Sept 29th*, 1929. He died before that I last saw him *reached him* and that death occurred, on the date stated above, at *7:30* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage of lung of which I saw plenty of condense.

(duration) *10 minutes*
CONTRIBUTORY (SECONDARY) *supposedly tuberculosis of lung* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *23A*
23B

IF NOT AT PLACE OF DEATH. *mo*
DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) *Boaz Bohling*, M. D.
9-30, 1929 (Address) *Sedalia 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 *Valda, mo.* DATE OF BURIAL *10/3 1929*

20. UNDERTAKER *Gillespie* ADDRESS *Sedalia*

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.

