

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

Do not use this space.

36030

DEC 22 1930

1. PLACE OF DEATH

County *Jackson* Registration District No. *398*
 Township *Blue* Primary Registration District No. *5554*
 City *Independence* (No. *1810*) *Harvard Ave.* St. _____ Ward _____

File No. _____
 Registered No. *337*

2. FULL NAME

Bertha Woodruff
 (a) Residence No. *Hackett* *Milburn* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov. 6 1930*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John Woodruff*

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 *8:30 a. m.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 10 1873*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 0 27

Cardiac Distention
7515
493
 (duration) _____ yrs. _____ mos. _____ ds.

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

CONTRIBUTORY (SECONDARY) *Porter Station*
 (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Happstad Iowa*

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

10. NAME OF FATHER *Charles W. Foster*

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

20. WAS THERE AN AUTOPSY? *Yes*

12. MAIDEN NAME OF MOTHER *Mary E. Crandall*

WHAT TEST CONFIRMED BY _____ (Signed) _____ M. D.

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

1930 (Address) *Indep. 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.

14. INFORMANT *Mr. Benton Foster*
 (Address) *8017 Waldron Road K.C. Mo*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Woods Chapel Cem* DATE OF BURIAL *Nov. 9 1930*

15. FILED *11-7-30* *F. C. Cook* REGISTRAR

20. UNDERTAKER *Waller & Son* ADDRESS *Indep. Mo*

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

