

*On Kravitz*

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

Do not use this space.

1. PLACE OF DEATH

73 County *Newton*  
Township *Newton*  
City (No. ....) St. .... Ward)

Registration District No. *108*  
Primary Registration District No. *5-11*

File No. *2518*  
Registered No. ....

2. FULL NAME *William T. Wood*

(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 *Husband *Walter Woods**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug. 6, 1851*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
*81* *5* *17*

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) *Wanda*. (STATE OR COUNTRY) *Newton Co.*

10. NAME OF FATHER *Tipton, O. Woods*

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

12. MAIDEN NAME OF MOTHER *Dollar*

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

14. INFORMANT *Ben Merkel*. (Address) *Newton*

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 22 1933*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 22 1933*, to *Jan 22 1933*, that I last saw him... alive on *Jan 22 1933*, and that death occurred, on the date stated above, at *5:30 a. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Cerebral Hemorrhage*

CONTRIBUTORY (SECONDARY) *82* *82* (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) *S. J. Marshall*, M. D.

*Jan 23, 1933* (Address) *Fairview 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 *Newton* *Newton Mo* DATE OF BURIAL *1/23 1933*

20. UNDERTAKER *Fairview Funeral Home* ADDRESS *Fairview Mo*

N. B. CAUSE OF DEATH



**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 Newton  
Township Newtonia  
City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 614  
Primary Registration District No. 5811

File No. 29  
Registered No. 5

**2. FULL NAME** William J. Wood

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 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) Aug 6 - 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
81 5 17

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

13. NAME Lipton O. Woods

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

15. MAIDEN NAME Fowler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Ben Gravel

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED Mar 13 1933 Dr. M. F. Colver Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 22 1933

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify S. A. Russell (Signed) \_\_\_\_\_, M. D.

(Address) Fairview

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

SUPPLEMENTARY

8152-5