APR 24 19

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

Do not use this space.

1. PLACE OF DEATH
County Scotland
Township Vest
City ..... (No. ..... St. ..... Ward)

Registration District No. 810
Primary Registration District No. 6059

File No. 12004
Registered No. 18

2. FULL NAME Lowell A. Woods
(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) Widower

5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8 1905

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
27	9	13	

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

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

PARENTS
10. NAME OF FATHER Stacey A. Woods
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Scotland Co Mo
12. MAIDEN NAME OF MOTHER Luella Donaldson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Scotland Co Mo

14. INFORMANT Stacey A Woods
(Address) Memphis Mo

15. FILED 3/22, 1933 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 21st. 1933.

17. I HEREBY CERTIFY, That I attended deceased from April 2nd. 1932, to February 2nd. 1933 that I last saw him alive on December 10th 1932, and that death occurred, on the date stated above, at 7.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Laryngeal Tuberculosis.

[illegible] (duration) ..... yrs. 18 mos. ..... ds.

CONTRIBUTORY (SECONDARY) [illegible]

..... (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) [signature], M. D
, 19 (Address) Memphis, 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 Camp Ground
DATE OF BURIAL Mar 27 1933
20. UNDERTAKER [illegible] Baskett
ADDRESS Memphis