

SEP 26 1935 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27431

226

1. PLACE OF DEATH

County St Francois Registration District No. 774
Township St Francois Primary Registration District No. 4465
City Flat River Mo No. _____ St. _____ Ward)

2. FULL NAME William Henry Wood

(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 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) July 4, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 6 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
(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 John Wood

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mountain View Mo

12. MAIDEN NAME OF MOTHER Ann Spurlock

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Not Known

14. INFORMANT Anna Evans (Address) Flat River Mo

15. FILED 9/4, 1935 B. B. Farrow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 25 1935

17. I HEREBY CERTIFY, That I attended deceased from _____, 1935, to _____, 1935, that I last saw him alive on _____, 1935, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Exam

(Signed) C. M. Stephens, M. D.

, 19 _____ (Address) Flat River 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 Bonne Terre Mo DATE OF BURIAL 8-27 1935

20. UNDERTAKER Go Diemer ADDRESS Flat River Mo

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.

