WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

21 1935

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

Do not use this space.

32388

1. PLACE OF DEATH Greene
County ..... Registration District No. 318 File No. .....
Township ..... Primary Registration District No. 77001 Registered No. 494
City Springfield (No. 1940 N. Freemont St. ..... Ward)

2. FULL NAME Wm. T. Woods
(a) Residence, No. 1940 N. Freemont 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~~ Nannie Frances Woods

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 26, 1868

7. AGE YEARS 66 MONTHS 11 DAYS 6 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
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) Christian Co. Mo.

FATHER
13. NAME Jackson Woods
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
15. MAIDEN NAME Elizabeth Caves
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Mrs. Tom Campbell (ADDRESS) Springfield, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Cemetery DATE Oct. 3 1935

19. UNDERTAKER (ADDRESS) J. W. Klingner & Co. Springfield, Mo.

20. FILED 10-3, 1935 R. W. Langston Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-2-1935

22. I HEREBY CERTIFY, That I attended deceased from 5-12-1933 to 10-2-1935
I last saw her alive on 10-2-1935 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:

	Date of onset
Cancer of Mouth and face	
Primary seat lower lip.	

Other contributory causes of importance: 45

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 .....
(Signed) W. Kelly, M. D.
(Address) Springfield Mo