

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

Do not use this space.

1. PLACE OF DEATH

97 County Scotland²
Township Vest
City _____ (No. _____)

Registration District No. 810
Primary Registration District No. 6057

File No. 30107
Registered No. 32
St. _____ Ward _____

2. FULL NAME

Margaret L. 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 4-1918

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, _____ hrs. or _____ min. |
|--------|-----------|----------|-----------|--|
| | <u>19</u> | <u>8</u> | <u>22</u> | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. attended

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. school

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) Scotland Co Mo

FATHER

13. NAME Leslie C. Woods

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

MOTHER

15. MAIDEN NAME Geldie Leace

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

17. INFORMANT (ADDRESS) S. A. Woods Memphis Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Camp Ground Aug 28 1938

19. UNDERTAKER (ADDRESS) Terri J. Dasher Memphis Mo

20. FILED SEP 3 - 1938 Registrar C. L. Tolson

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 26 1938

22. I HEREBY CERTIFY, That I attended deceased from May, 1938, to Aug 26, 1938
I last saw him alive on Aug 24, 1938 Death is said to have occurred on the date stated above, at 10:45 P.M.

The principal cause of death and related causes of importance were as follows:
Laryngeal Tuberculosis Date of onset 1934

Other contributory causes of importance:
23 -

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? _____, specify _____

(Signed) W. C. Allison, M. D.
(Address) Memphis Mo

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1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No..... St..... Ward)

File No.....
Registered No.....

2. FULL NAME.....

(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..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word).....

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

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

| | | | | |
|--------|-------|--------|------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-------|--------|------|--|

| | | |
|------------|---|--|
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc..... | 11. Total time (years) spent in this occupation..... |
| | 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)..... | |

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

| | |
|--------|--|
| FATHER | 13. NAME..... |
| | 14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)..... |

| | |
|--------|--|
| MOTHER | 15. MAIDEN NAME..... |
| | 16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)..... |

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL
PLACE..... DATE....., 19.....

19. UNDERTAKER (ADDRESS).....

20. FILED.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)....., 19.....

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., 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:

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.....

(Signed)....., M. D.

(Address).....

RECEIVED

District Health Officer, No. 10 Registrar.

District File Number 10-38-125

Day Filed 9-15-38