

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.

1939 APR 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

12724

Do not use this space.

1. PLACE OF DEATH

(a) County Worth Registration District No. 90-8904
 (b) Township Union Primary Registration District No. 6-13 Registered No. _____
 (c) City Leadona (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 300 Mary Ann Wood St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John B. Wood
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 1, 1849
 7. AGE YEARS 89 MONTHS 7 DAYS 9 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as 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) Liberty, Mo. (STATE OR COUNTRY) Clay County

FATHER 13. NAME William Warren
 14. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Mary Elizabeth Hedrick
 16. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) Ann Rumion
Leadona

18. BURIAL, CREMATION, OR REMOVAL PLACE Leadona DATE 3/12/39

19. FUNERAL DIRECTOR (NAME) W. H. H. H. (ADDRESS) _____

20. FILED 4-8 19 39 Fred M. M. M. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/10, 19 39
 22. I HEREBY CERTIFY That I attended deceased from Jan 1, 19 37, to Mar 10, 19 39
 I last saw him alive on 3-7-39, 19 39 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:
Epulis of lower jaw Date of onset _____
Senility

Other contributory causes of importance: 115 lb

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) _____ (Address) _____

RECEIVED
District Health Officer
District File Number 39-367
Date Filed APR 12 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

W. B. Haas

Licensed Embalmer No.

3899

P. O. Address

Grant City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.