

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.

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

22460
Do not use this space.

1. PLACE OF DEATH *Johnson* ²
 (a) County *Johnson* Registration District No. *431*
 (b) Township *1* Primary Registration District No. *30.23* Registered No. *85*
 (c) City *Warrensburg* (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence to 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 *Ida Lillie Wood*
 (a) Residence, No. _____ 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 *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widow*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Wm. R. Wood*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec. 11 - 1868*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 6 17
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housekeeper*
 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 *0 9 1*
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Odesa Mo.*
 FATHER 13. NAME *Wm. Rensselaer Brown*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Unknown*
 MOTHER 15. MAIDEN NAME *Unknown*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Unknown*
 17. INFORMANT (ADDRESS) *E. B. Wood Warrensburg, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *McKendree Cem.* DATE *June - 29 - 1939*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Supency - Phillips Warrensburg, Mo.*
 20. FILED *June 29, 1939* *Edna Gentry* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June - 28 - 1939*
 22. I HEREBY CERTIFY, That I attended deceased from *June 4 1939* to *June 28, 1939*
 I last saw her alive on *June 27, 1939*. Death is said to have occurred on the date stated above, at *11 A.M.*
 The principal cause of death and related causes of importance were as follows:
Acute Pericarditis Date of onset *June 4*
 Other contributory causes of importance: *90*
Senility
 Name of operation *none* Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? *no*
 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? *No*
 If so, specify _____
 (Signed) *John H. Powers*, M. D.
 (Address) *Warrensburg, Mo.*

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

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, _____

Earl Priest

_____ or by _____

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

Signed *Earl Priest*

Licensed Embalmer No. *3878*

P. O. Address *Warrensburg*

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.