

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 I X1931

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.

1. PLACE OF DEATH Mississippi

(a) County Mississippi

(b) City or town East Prairie
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: East Prairie Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 4 mo.
years, months or days

3. (a) PRINT FULL NAME WILSON WOODS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased June 26 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Mississippi Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Charley Woods

13. Birthplace Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Hensetta Spillers

15. Birthplace Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charley Woods

(b) Address East Prairie, Mo.

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof July 3, 1939
(Month) (Day) (Year)

(c) Place: burial or cremation Parish

18. (a) Signature of funeral director Francis Shelby

(b) Address East Prairie

19. (a) July 29 (b) Miss. M. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

(c) City or town East Prairie, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1939 hour _____ minute 70 M.

21. I hereby certify that I attended the deceased from June 16 1939, to July 2 1939

that I last saw him alive on June 16 1939 and that death occurred on the date and hour stated above.

Immediate cause of death: Iles. Colitis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature Geo W Whitaker (M. D. or other) _____

Address East Prairie Mo Date signed 7/6/39

RECEIVED

District Health Officer No. 2,

District File Number 839150

Date Filed 8-14

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.....

Licensed Embalmer No.....

P. O. Address.....

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.