

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

32478
Do not use this space.

OCT 1 1939

1. PLACE OF DEATH
 (a) County Henry Registration District No. 347
 (b) Township Clinton Primary Registration District No. 3018 Registered No. _____
 (c) City Clinton (d) Street No. Clinton General 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 Amanda E. Woolf
 (a) Residence, No. Post Oak mo (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Wid)
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF James W woolf
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 15 1911
 7. AGE YEARS 27 MONTHS 1 DAYS 2 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) (STATE OR COUNTRY) Lawrence mo
 FATHER 13. NAME Phillip W Moore
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky
 MOTHER 15. MAIDEN NAME Mary Crosswhite
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) north mo
 17. INFORMANT (ADDRESS) Tim's Bradley Clinton mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Shawnee mound DATE 9/19 39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Consalus & Beck Clinton mo
 20. FILED 9-23 39 Dr. J. R. Hays Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-17 1939
 22. I HEREBY CERTIFY, That I attended deceased from 9-16, 1939, to 9-17, 1939. I last saw him alive on 9-17, 1939. Death is said to have occurred on the date stated above, at 11 P. m.
 The principal cause of death and related causes of importance were, as follows:
Coronary Arteriosclerosis
54
 Other contributory causes of importance:
Diabetes Complicated with gangrene of feet?
 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) J. R. Hays, M. D.
 (Address) Clinton mo

Walter

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

MARGIN RESERVED FOR BINDING

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.

FORM 1-12-38
1 X10223

STATEMENT BY LICENSED EMBALMER
FOR THE DISTRICT OF COLUMBIA
HEALTH DEPARTMENT

HEALTH DEPARTMENT

STATEMENT BY LICENSED EMBALMER

FOR THE DISTRICT OF COLUMBIA

HEALTH DEPARTMENT

HEALTH DEPARTMENT

RECEIVED

District Health Officer No. 7,

District File Number 7-29-1379

Date Filed 10-1-29

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,

M. H. Snow

or by

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

Signed

M. H. Snow

Licensed Embalmer No.

4034

P. O. Address

Clinton MD

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.