

Registration District No. 107

Primary Registration District No. 4062

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Auxvasse Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution x (Specify whether _____)
In this community Life
years, months or days

3. (a) PRINT FULL NAME

Luther L. Woolery ⁴⁶⁰

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertie Woolery

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased June 7 1886
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>53</u>	<u>6</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace

Auxvasse Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name John Woolery

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

14. Maiden name Lizzie Buckner

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

16. (a) Informant's own signature

Bertie Woolery

(b) Address Auxvasse Mo.

17. (a) Burial (b) Date thereof Feb. 6-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hills

18. (a) Signature of funeral director

Hughes Marqu

(b) Address Auxvasse, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

11 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway
(c) City or town Auxvasse
(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.? x years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4th
year 1940 hour 7 minute _____ A. M.

21. I hereby certify that I attended the deceased from Sept. 28
1939, to Jan 20, 1940;
that I last saw him alive on Jan 20, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral involvement of pyogenic
Biliary Abscess
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Donnan (M. D. or other) _____
Address Auxvasse Mo. Date signed 2-5-40

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.

5 00 31 10 1417

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 Hughes M. Manpin
Licensed Embalmer No. 2358
P. O. Address Quincy, Va. 22130

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6112

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Luther S. Woolery

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 53 Months Days If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(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.

20. DATE OF DEATH: Month Feb. day 4-40
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma (abdominal)
Due to Involvement of biliary passages
Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy.....

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?

While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature [Signature] (M. D. or Public Health Officer)
Address Amos Dr Date signed 3-6-41

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6112

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 102

Primary Registration District No. 4062

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Callaway
(b) City or town Auparse
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Luther L Woolery

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

4. Sex m 5. Color or race negro 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 53 Months 6 Days 27 If less than one day, hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb 4 1940 (b) L B Nichols
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Feb day 4
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature O. H. Domann (M. D. or other)

Address Auparse Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY