No. 2
1-10-39
-17-39
X21492

8

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED MAR 16 1940

State File No. 6898

Registration District No. 396 Primary Registration District No. 5552 ~~396~~ Registrar's No. 5552

1. PLACE OF DEATH:

(a) County Jackson Fort Bd.
(b) City or town 4 Mi West Sibley Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at home 2
(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 30 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Fort Mo (b) County Jackson
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. X
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME William Andrew Wood, 3rd
3. (b) If veteran, name war X
3. (c) Social Security No. ✓
4. Sex Male
5. Color or race White
6. (a) Single, ~~widowed, married~~, divorced Single
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased June (Month) 23 (Day) 1857 (Year)

8. AGE: Years 82 Months 7 Days 12 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)
10. Usual occupation Farming
11. Industry or business Farming
FATHER
12. Name Samuel Wood
13. Birthplace (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name Christiana Spangle
15. Birthplace (City, town, or county) Penn (State or foreign country)
16. (a) Informant William G. Graham Bluejoint
(b) Address Mo
17. (a) Buckner Cem (Burial, cremation, or removal) (b) Date thereof Feb 6 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Buckner County
18. (a) Signature of funeral director O W Mitchell
(b) Address Independence Mo
19. (a) 2-4-40 (Date received local registrar) (b) John W Robertson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4th day Feb. year 1940 hour 11 minute 50 A.M.
21. I hereby certify that I attended the deceased from Jan 11, 1940, to Feb 4, 1940 that I last saw him alive on Feb 3 – 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Mitral Regurgitation	
Due to	
Due to Influenza 92 W	✓
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy no	

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

23. Signature John W Robertson (M. D. or other) 1
Address Buckner Date signed 2-4-40

(Unused Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County .....

(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 years, months or days)
In this community .....

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.

3. (a) PRINT FULL NAME .....

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

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

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... 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 ..... Duration

Due to .....

Due to .....

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? .....

Major findings .....
(Include pregnancy within 3 months of death)

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

Of autopsy .....

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 ..... working under my personal supervision.

Registered Apprentice No. .....

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.

(Reverse Side)

DISCHARGE RECORD

WHITE PAPER—USE UNIFORM BLACK INK—MAKE 4 IMPRINTS

No. 2
1-10-39
17-39
X8182