

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10804

Registration District No. 253, Primary Registration District No. 53513

Registrar's No.

1. PLACE OF DEATH:
(a) County DeWitt Co Mo
(b) City or town Jamesport Mo
(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 2 (Specify whether ✓)
In this community 2 years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County DeWitt
(c) City or town Jamesport (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME HENRY J. WOOD
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 18
year 1940 hour _____ minute _____ M.

4. Sex ✓ 5. Color or race white 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: Oct 25 1897
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 8 to Jan 17, 1940
that I last saw him alive on Jan 10, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death Leutontis Duration _____

8. AGE: Years Months Days If less than one day
82 2 22 hr. min.

Due to Obstruction of bowel
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____

10. Usual occupation Farmer

Of autopsy _____

11. Industry or business _____

MOTHER FATHER
12. Name David
13. Birthplace Green Mississippi
(City, town, or county) (State or foreign country)
14. Maiden name Mary M. Eubank
15. Birthplace Ward Mo
(City, town, or county) (State or foreign country)

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 places? 230
While at work? _____ (Specify type of place) (e) Means of injury 3

16. (a) Informant Mrs O. S. Shepard
(b) Address Jamesport Mo

23. Signature J. B. Bailey (M. D. or other) J. B.
Address Jamesport Date signed 1-20-40

17. (a) _____ (b) Date thereof 13
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation 3 Jamesport

18. (a) Signature of funeral director J. B. Robertson
(b) Address Jamesport Mo

19. (a) Jan 17 (b) W. H. Mierisch
(Date rec'd by local registrar) (Registrar's signature)

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

31

12212

RECEIVED
District Health Officer No. 11,
District File Number 440-550
Date Filed APR 13 1940

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 *O. L. Robinson*

Licensed Embalmer No. 3244

P. O. Address *Jamestown Mo*

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. 10804

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 253

Primary Registration District No. 535-113

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Dwight
(b) City or town Jackson, 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 _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Henry L. Wood

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

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

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

7. Birth date of deceased Oct 25 (Month) 185 (Day)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>2</u>	<u>22</u>	_____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Aug 22, 1940 (Date received local registrar) (b) A. J. Minnis (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 Jan day 17
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 _____

N. M. D. - on repeated

Due to query - 10-9-40

Due to _____

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

Major findings: Of operations 122B

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 F. B. Bailey (M. D. or other) _____

Address Jamesport Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

5-10 804

1990