

Registration District No. 89-75

Primary Registration District No. 513-1-5990

State File No. _____

Registrar's No. 197

1. PLACE OF DEATH:

(a) County Ripley
 (b) City or town Thomas Twp
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution
3 miles South of Naylor Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no
 (Specify whether
 In this community _____
 years, months or days) 2 1/2

8. (a) PRINT FULL NAME Barnett Everett Woodward

8. (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 Sarah Woodward 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 23 1888
 (Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name R. Anderson Woodward

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

14. Maiden name Sarah Robinson

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

16. (a) Informant Ayton Mendenhall

(b) Address _____

17. (a) Burial (b) Date thereof June 23 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baton Camp

18. (a) Signature of funeral director Missouri Fish

(b) Address Naylor

19. (a) 7-9-40 (b) Stutzinger
 (Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ripley
 (c) City or town Thomas Twp
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3 miles South of Naylor
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
 year 1940 hour 1 minute _____ P.M.

21. I hereby certify that I attended the deceased from June 20, 1940 to June 22, 1940
 that I last saw him alive on June 21, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Paralytic and hemorrhagic from the brain

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? _____

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

23. Signature J. J. Dan (M. D. or other) ✓
 Address Naylor Date signed _____

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

10-39
7-39
X21492

22

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

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 Bryan McCord
Licensed Embalmer No. 4079
P. O. Address Naylor, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22659**

Registration District No. **757**

Primary Registration District No. **5990**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Ripley
(b) City or town Thomas T.P.
(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 Ernest Everett Woolard
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex m **5. Color or** W **6. (a) Single, widowed, married,** m
race W **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 52 Months 5 Days 29 If less than one day _____ hr. _____ 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) _____ **(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 6 day 22
year 1970 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 Paralysis and
hemorrhage from being
Cerebral Hemorrhage
Due to _____
Due to _____

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

Major findings: g2w
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? _____
_____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature: _____ (M. D. or other) _____
Address: _____ **Date signed:** _____

SUPPLEMENTAL COPY

PHYSICIAN

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22659**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **751**

Primary Registration District No. **5996**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Ripley**
 (b) City or town **Thosmas T.P.**
(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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **mo** (b) County **Ripley**
 (c) City or town **Rural**
(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 **Earnest Everett Woolard**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH Month **6** day **22**
 year **1940** hour _____ minute _____ M. _____

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

7. (b) Name of husband or wife **Sarah Woolard** (c) Age of husband, or wife, if alive _____ years
 7. Birth date of deceased **Dec 13 1888**
(Month) (Day) (Year)

Immediate cause of death **Paralysis and Hemiplegia from the**
 Due to **stroke**

8. AGE: Years **52** Months **5** Days **9** If less than one year _____ min. _____

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

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

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

10. Usual occupation **Farm**

Major findings:
 Of operations _____
 Of autopsy _____

11. Industry or business _____

Underline the cause to which death should be charged statistically.

12. Name **R. Anderson Woolard**

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

14. Maiden name **Sarah Robinson**

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

16. (a) Informant **Afton Meendenhall**

17. (a) Burial (b) Date thereof **6-23-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director **Eaton Cem**
Minnie Smith
Naylor

19. (a) Aug 15 40 (b) **H.E. White**
(Date received local registrar) (Registrar's signature)

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. J. Farr** (M. D. or other) _____
 Address **Wesleyville** _____

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

TEMPORARILY