

NOV 2 1940

STANDARD CERTIFICATE OF DEATH

State File No. 35151

Registration District No. 233

Primary Registration District No. 531A

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Francois  
 (b) City or town Rolla  
 (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 years, months or days)

3. (a) PRINT FULL NAME Mrs Rosa Woods

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

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

(b) Name of husband or wife Samuel Woods 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 19 1883  
 (Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Sidney Service

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

14. Maiden name Know

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

16. (a) Informant Edna Williams

(b) Address Leasburg Mo

17. (a) Burial (b) Date thereof 10-20-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macedonia Cem

18. (a) Signature of funeral director Willson

(b) Address Rolla Mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County  Phelps  
 (c) City or town Rolla  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 215  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18  
 year 1940 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from Jan 1 1940 to Oct 18 1940  
 that I last saw him alive on Sept 15 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of the heart Duration 3 hrs

Due to Chronic myocarditis & decompensation 6 mo.

Due to \_\_\_\_\_

Other conditions Chr nephritis 3 mo.  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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?  
209  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. E. Faid (M. D. or other) MD  
 Address Box 534 Rolla Mo. Date signed 10-18-40

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

5-17-39  
 X21492

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

*S. L. Jones*

Licensed Embalmer No.

*3394*

P. O. Address

*Rolla, 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. 35-157

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 233

Primary Registration District No. 5318

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Crawford  
(b) City or town Liderty  
(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 Mrs Rosa Woods

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

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 37 Months 1 Days 29 If less than one day \_\_\_\_\_ h. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 12-13-40 (b) W. F. Irvine M.D.  
(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 Oct day 18  
year 1940 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 \_\_\_\_\_

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 E. E. Fend (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

KOWENA MOORE

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

SUPPLEMENTAL

