CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39122

Registration District No. 496 — Primary Registration District No. 3025 — Registrar's No. 93

DEC 11 1940

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Brookfield Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)

In this community 41 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Brookfield (If outside city or town limits, write "RURAL")

(d) Street No. 905 Brookfield Ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME William Cole Atwood

3. (b) If veteran, name war ____

3. (c) Social Security No. None

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Laura Knox Atwood

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased May (Month) 21 (Day) 1859 (Year)

8. AGE: Years 81 Months 6 Days 1 If less than one day ____ hr. ____ min.

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

10. Usual occupation Retired Minister

11. Industry or business ____

FATHER
12. Name James E. Atwood
13. Birthplace ____ (City, town, or county) England (State or foreign country)

MOTHER
14. Maiden name Mary Cole
15. Birthplace ____ (City, town, or county) England (State or foreign country)

16. (a) Informant's own signature [signature]

(b) Address Ajo, Arizona

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24 (Month) 1940 (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Hill Funeral Chapel

(b) Address Brookfield Mo

19. (a) 11/23/40 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22 year 1940 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from Nov - 12 -, 1940, to Nov - 22 -, 1940, that I last saw him alive on Nov - 22 -, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	10 Dy
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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 [signature] (M. D. or other)

Address Brookfield Mo Date signed 11/23/40

(Licensed Embalmer's Statement on Reverse Side)

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 J. H. Blacklock, Registered Apprentice No. ..... working under my personal supervision.

Signed J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.