

Registration District No. 903 Primary Registration District No. 6211 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Rural Smith Purg.
(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 68 yrs. (years, months or days)

3. (a) PRINT
FULL NAME

NELLIE WOOD

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

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 8 1872 (Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Hampton Wood
13. Birthplace Unknown 19 Tennessee (City, town, or county) (State or foreign country)
14. Maiden name Isadora Wood
15. Birthplace Unknown Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Hampton Wood
(b) Address Allenale Mo.

17. (a) Rural (b) Date thereof 6-23-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Allenale Cem.

18. (a) Signature of funeral director Dr. C. D. Dyer
(b) Address Trant City Mo.

19. (a) June 23, 1941 (b) Clifford Hoss (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth
(c) City or town Rural Smith Purg. (If outside city or town limits, write "RURAL")
(d) Street No. Allenale (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country r

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20 year 1940 hour 8:00 minute 0 P- M.

21. I hereby certify that I attended the deceased from Jan. 4-41 to June 20, 1941; that I last saw her alive on June 18, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Regeneration of heart Duration 1 1/2 yrs

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? 96.8

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

23. Signature Dr. C. D. Dyer (Date signed 6-21-41)
Address Trant City Mo.

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.....

Arch C. Dinglee

Licensed Embalmer No. *3252*

P. O. Address. *Grant City, 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23035

Registration District No. 903

Primary Registration District No. 6211

Registrar's No. _____

1. PLACE OF DEATH

(a) County Wood
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Hellie Wood

3. (b) If veteran, _____
name war _____

3. (c) Social Security _____
No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 8
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 8 1872
(Month) (Day) (Year)

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

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

10. Usual occupation Farming & stock raising

11. Industry or business _____

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 1941 (b) Clifford H. Hays
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 20
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 _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-23035