

FILED SEP 26 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31985

1. PLACE OF DEATH

County Marion
Township Johnson
City Safe, Mo. (No. 1)

Registration District No. 546
Primary Registration District No. 579

File No. 11
Registered No. 11 Ward 0

2. FULL NAME Francis E. Woodruff

(a) Residence, No. Safe, Mo. St. Mo. Ward 0

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John J. Woodruff

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 24, 1859

7. AGE YEARS 81 MONTHS 9 DAYS 11 If LESS than 1 day, hrs. min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Owensville (STATE OR COUNTRY) Mo.

13. NAME Samuel R. Nicks

14. BIRTHPLACE (CITY OR TOWN) England (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Annie Hodgson London

16. BIRTHPLACE (CITY OR TOWN) England (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) C. P. Woodruff Safe, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE High Gate Cem. DATE Sept. 7, 1941

19. UNDERTAKER (ADDRESS) S. G. Licklider Belle, Mo.

20. FILED Sep 10 - 1941 Sam A. Warner Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 5, 1941

22. I HEREBY CERTIFY, that I attended deceased from Sept 2 to Sept 5, 1941

I last saw deceased alive on Sept 4, 1941. Death is said to have occurred on the date stated above, at 4:15 p.m. The principal cause of death and related causes of importance were as follows:

Uremia Date of onset 4/1

Other contributory causes of importance:

Name of operation None Date of 4/1
What test confirmed diagnosis? None Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? None Date of injury 4/1

Where did injury occur? None (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify None
(Signed) J. B. Woodruff M. D.
(Address) High Gate Mo.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31985

Registration District No. 546

Primary Registration District No. 5735

Registrar's No. 11

1. PLACE OF DEATH:

- (a) County Marion
(b) City or town Johnson
(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

Francis E. Woodruff

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex M 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 _____ years

7. Birth date of deceased Nov 24 18
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day
hr. _____ min.

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

10. Usual occupation _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) 10-1941 (b) Sam G. Warner
(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 Dec day 1
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death uremia Duration _____

- Due to chronic nephritis

- Due to _____

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

- Major findings:
Of operations _____

- Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 _____

1941

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