

No. 2
4-13-40
-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37434

State File No. _____

DEC 22 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4229

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Mo. & 15 days
(Specify whether)
 In this community 60 Years
years, months or days

3. (a) PRINT FULL NAME William John W. Wood

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

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

6. (b) Name of husband or wife Mrs. Abbie P. Wood 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased September 23 1853
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | 88 | 1 | 18 | hr. min. |

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

10. Usual occupation Representative

11. Industry or business Mutual Life Insurance Co.

12. Name David Wood

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

14. Maiden name Mary Ming

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

16. (a) Informant Amos P. Wood

(b) Address 27 E 67th St.

17. (a) Burial (b) Date thereof Nov. 13, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director W. H. Newcomer Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 11-13-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 2620 East 30th St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11th year 1941 hour 10 minute 14 A.M. M.

21. I hereby certify that I attended the deceased from 9-27-41 to 11-11-41, 19____; that I last saw him alive on 11-11-41, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Multiple pathological fractures of undetermined origin and Senility

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

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
See above

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)
 (c) Means of injury _____
 23. Signature Dr. R. K. Crowe (M. D. or other)
 Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

Emile M. Calhoun

Licensed Embalmer No. *3506*

P. O. Address *K.C. 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **4229**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town.....
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K.C. General Hospital No. 1
 (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 **John W. Wood**

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, 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 **88** Months **1** Days **18** 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) **11/13/41** (b) **M. M. Brown** (c) Registrar's signature
 (Date received local registrar)

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 **Nov.** day **11th**
 year **1941** 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.....

Multiple pathological fractures of undetermined origin and senility

Due to.....
 Due to..... **155**

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 **Wm. R. Brown** (M. D. or other).....
 Address..... Date signed.....

PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-37434

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.