

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11601**
Registrar's No. **112**

Registration District No. **268**

Primary Registration District No. **3032**

1. PLACE OF DEATH:

(a) County **Pettis**
(b) City or town **Sedalia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **116 1/2 East 5th. St. /**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 Years** (Specify whether
In this community **50 Years** years, months or days)

3. (a) PRINT FULL NAME **Lorena H. Woolery**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **No.** 6. (c) Age of husband or wife if alive **1868** years
7. Birth date of deceased **Aug. 15** (Month) (Day) (Year)

8. AGE: Years **73** Months **7** Days **3** If less than one day hr. min.

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

10. Usual occupation **At Home**

11. Industry or business **No.**

12. Name **Jacob Woolery**
13. Birthplace **Cooper Co. Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Caroline Thomas**
15. Birthplace **Cooper Co. Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Miss Belle Woolery**
(b) Address **Sedalia, Mo.**

17. (a) **Burial** (b) Date thereof **3/20/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crown Hill**

18. (a) Signature of funeral director **Geo. Dillard**
(b) Address **Sedalia**

19. (a) **3/20/42** (b) **Miss Anna Berger**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pettis**
(c) City or town **Sedalia**
(If outside city or town limits, write "RURAL")
(d) Street No. **116 1/2 East 5th. St.** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **18** year **1942** hour **9:50** minute **17** M.

21. I hereby certify that I attended the deceased from **May 1941** to **March 18** 19 **42**
that I last saw him or her alive on **March 17** 19 **42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary - vascular disease - renal disease** Duration **2 years**

Due to **Agk & Arterio**
Coronary - vascular disease

Due to **No.**
Other conditions **13/10**
(Include pregnancy within 3 months of death)

Major findings: **No.**
Of operations **No.**

Of autopsy **No.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No.**
(b) Date of occurrence **No.**

(c) Where did injury occur? **No.** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **No.**

While at work **No.** (Specify type of place) (Specify means of injury)

23. Signature **Geo. Dillard** (M.D. or other) **No.**
Address **Sedalia, Mo.** Date signed **3/20/42**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-10-42

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.....

L. E. Boulton

Licensed Embalmer No. 3867

P. O. Address. *Seelawia*

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.