

BUREAU OF THE CENSUS  
FILE NO. NC 12 19428

Registration District No. \_\_\_\_\_

Primary Registration District No. 200D

Registrar's No. 744

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution Springfield Baptist Hospital  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence <sup>55</sup>

(c) City or town Miller <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location) R.R.

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

3. (a) PRINT FULL NAME Laura May Woody

3. (b) If veteran, name war NO

3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15 year 1942 hour 6 minute 45 P. M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Fred Woody

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased: \_\_\_\_\_  
(Month) (Day) (Year) 5 - 4 - 1896

21. I hereby certify that I attended the deceased from Oct 12, 1942 Oct 15 - 1942 that I last saw her alive on Oct 15, 1942 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>46</u>	<u>5</u>	<u>11</u>	hr. _____ min.

Immediate cause of death Cerebral Thrombosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Lawrence Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy None

11. Industry or business \_\_\_\_\_

12. Name Thomas Clarkson

13. Birthplace Greene Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name LIZZIE JOHNSON

15. Birthplace Greene Co. Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Fred Woody

(b) Address Miller Mo.

17. (a) Buried (b) Date thereof 10-18-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johns Chapel

18. (a) Signature of funeral director Morris Kemmer

(b) Address Miller Mo.

19. (a) 10-11-42 (b) B. W. Handley  
(Date received local registrar) (Registrar's signature)

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) (Means of injury)

23. Signature E. C. Roberts (M. D. or other) \_\_\_\_\_

Address Springfield, Mo. Date signed \_\_\_\_\_

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

X23159

**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 E. R. Leiman  
Licensed Embalmer No. 3297  
P. O. Address Miller MO.

**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.

STANDARD CERTIFICATE OF DEATH

State File No. 33781  
Registrar's No. 744

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Sauva May Woody  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
(Immediate cause of death) Cerebral tumor

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased: May 4  
(Month) (Day) (Year)

Due to Patient unconscious when first seen. Diag. made solely from clinical findings; no operation, no autopsy, therefore, unable to state character of tumor.  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: Of operations No operation 57d  
Of autopsy No autopsy  
Duration Not known

8. AGE: Years 46 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Mo

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 E. C. Roseberry (M. D. or other) \_\_\_\_\_

Address 618 Woodruff Bldg. Date signed 11/30/42

Springfield, Mo.

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

SUPPLEMENTARY

S-33781

1942