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7-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 15 2996

FILED FEB 13 1943  
Registration District No. 2-2-1

Primary Registration District No. 20-4-8-5 9.53

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

1. PLACE OF DEATH:  
(a) County Nodaway  
(b) City or town Marionville, Rural, Polk's Ins  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Nodaway County Infirmary 5  
(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 Nodaway  
(c) City or town Elma (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Wyatt Wood  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 28  
year 1943 hour 9 minute 15 P.M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 3 divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 2 5 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 30, 1942 to Jan 28, 1943;  
that I last saw him alive on Jan 28, 1943;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
74 11 23 hr. \_\_\_\_\_ min.

Immediate cause of death cardiac asthma Duration 5 hrs

9. Birthplace Wappalo county Iowa  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
95c

11. Industry or business \_\_\_\_\_  
12. Name Riley Wood  
13. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Lorinda FRAZER

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy none  
Underline the cause to which death should be charged statistically.

15. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs E.E. Nichols  
(b) Address Burlington Jet, Missouri  
17. (a) Burial (b) Date thereof 1-31-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Braddyville Iowa  
18. (a) Signature of funeral director Campbell Funeral Home  
(b) Address Marionville Mo  
19. (a) 2-1-43 (b) Mary Cole  
(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) (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Signature] Date signed 1/30/43

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**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 *W. Dean Campbell*.....

Licensed Embalmer No. *2620*.....

P. O. Address *Marysville 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.**