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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24621

FILED AUG 11 1943

Registration District No. 3 Primary Registration District No. 3010 Registrar's No. 211

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 8 days (Specify whether years, months or days)
In this community: 8 days

2. USUAL RESIDENCE OF DECEASED: 100
(a) State: Mo (b) County: Scott 0
(c) City or town: R.F.D. Illmo 0
(If outside city or town limits, write "RURAL")
(d) Street No.: Tekso Twp.
(If rural, give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: William Sullivan Woolsey
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Jessie Wade Woolsey
6. (c) Age of husband or wife if alive: 50 years
7. Birth date of deceased: Jan (Month) 30 (Day) 1894 (Year)

8. AGE: Years 49 Months 5 Days 3 If less than one day ____ hr. ____ min.

9. Birthplace: Tas Kas Kia Island (City, town, or county) Ill (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Sylvester Woolsey
FATHER 13. Birthplace: Kas Kas Kia Island (City, town, or county) Ill (State or foreign country)
MOTHER 14. Maiden name: Theresa Cossoul
MOTHER 15. Birthplace: Tas Kas Kia Island (City, town, or county) Ill (State or foreign country)
16. (a) Informant: Mrs Carroll Wade
(b) Address: Oran Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 5 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Benton Mo
18. (a) Signature of funeral director: Bispinghoff & Nubbar
(b) Address: Jll Mo
19. (a) 7-4-43 (Date received local registrar) (b) F. H. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1943 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from June 25 1943, to July 3 1943, that I last saw him alive on 7/5/43, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lues	
Diabetes Mellitus	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 30 g	

Major findings:
Of operations:
Of autopsy:

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: H. Lee M.D. (M. D. or other) MD
Address: Illmo Mo Date signed: 7/4/43

1014 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 843-2548

Date Filed 8-10-43

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 Mamie Bispleng Huff

Licensed Embalmer No. 3242

P. O. Address Chaffee 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.