

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

38117

Registration District No. 79

Primary Registration District No. 5375

Registrar's No. 157

1. PLACE OF DEATH:

(a) County DEKALB - Dallas TWP

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

(c) Name of hospital or institution: 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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County DEKALB

(c) City or town DAYSVILLE (DALLAS) MO
(If outside city or town limits, write "RURAL")

(d) Street No. Rural R-3
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME BENJAMIN HARRISON WOOD

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 30
year 1943 hour 5 minut 30 a.m.

21. I hereby certify that I attended the deceased from June 18
1943 to 10-29- 1943
that I last saw him alive on Oct 6 1943
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife CLEMENCE WOOD 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased NOV 13 1888
(Month) (Day) (Year)

Immediate cause of death.....
Tuberculosis Both Lungs

Duration Known

8. AGE: Years 54 Months 11 Days 17 If less than one day hr. min.

9. Birthplace DEKALB Co. (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)

MOTHER FATHER

11. Industry or business

12. Name LEVI WOODS

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

14. Maiden name LAVINE GRAHAM

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

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Clemence Wood

(b) Address Maysville Mo

17. (a) Burial (b) Date thereof 11-1-43
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Episcopal Church

18. (a) Signature of funeral director Charles L. Wingle

(b) Address Maysville Mo

19. (a) 11-3-43 (b) C. L. Perkins
(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 C. L. Perkins (M. D. or other).....
Address Charlottesville Mo Date signed 11/2/43

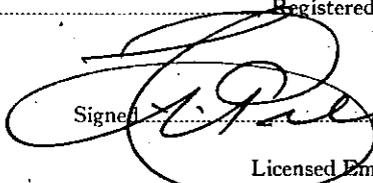
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1278

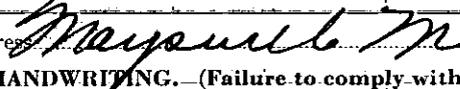
STATEMENT BY LICENSED EMBALMER

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. 3960

P. O. Address



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.