

FILED MAY 10 1944

Registration District No. 7120

Primary Registration District No. 5465

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural, N. Campbell Twp.
(c) Name of hospital or institution: Peace Rest Home #4
(d) Length of stay: In hospital or institution 1 mo - 3 days
In this community 3 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Marion Mo
(d) Street No. 3
(e) Citizen of foreign country? No
If yes, name country 1

3. (a) PRINT FULL NAME

David C. Woods

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

3. (c) Social Security No. Unk.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Leola

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

7. Birth date of deceased Aug 21 - 1870

8. AGE: Years 73 Months 7 Days 28 If less than one day hr. min.

9. Birthplace Marion Mo, D

10. Usual occupation Abstract-Business

11. Industry or business Garage Proprietor

12. Name John C. Woods

13. Birthplace Unk. A

14. Maiden name Mary E. Unk.

15. Birthplace Unk. A

16. (a) Informant Mrs. Helen Masere

(b) Address Marion Mo

17. (a) Burial (b) Date thereof Apr 21 - 1944

(c) Place: burial or cremation 1007 Elm

18. (a) Signature of funeral director Geo. A. Orr

(b) Address Marion Mo

19. (a) 4-21-44 (b) (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day April 19
year 1944 hour 3 minute 15 P-M.

21. I hereby certify that I attended the deceased from 4, 18, 44 19... to 4, 19, 44 19...
that I last saw him alive on 4, 18, 44 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Heorrhage, cerebral Duration 1 day

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
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) (c) Means of injury.....

23. Signature J. D. Mueck Mo (M. D. or other)
Address Springfield, Mo. Date signed 4, 20, 44

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

MOTHER FATHER

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.....

Geo. B. Orr

Licensed Embalmer No.....

946

P. O. Address.....

Mr. Vernon J. ...

MAY 19 1944

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.

X

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 350

Registration District No. 128

Primary Registration District No. 5465

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural N. Campbell Imp.
(If outside city or town limits, write "RURAL" and name of township)
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME David C. Woods

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Aug 21
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 3 If less than one day..... min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-21-48 (b) D. W. Handley
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1944 hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from..... 19.....

that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage, cerebral
Duration 1 day

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

14732