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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 28 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27628

State File No.

Registration District No. 100

Primary Registration District No. 3018

Registrar's No. 54

1. PLACE OF DEATH:
 (a) County Dent
 (b) City or town Salem
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Dent 33
 (c) City or town Salem 1
(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 1

3. (a) PRINT FULL NAME Mary Francis Woodland
 3. (b) If veteran, name war.
 3. (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month August day 7
 year 1944, hour 2 minute 30 P. M.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced M. I.
 6. (b) Name of husband or wife O. Oliver Woodland 6. (c) Age of husband or wife if alive 77 years
 7. Birth date of deceased Sept 7- 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 12, 1944 to Aug 7, 1944
 that I last saw her alive on Aug 7, 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months 10 Days 29 If less than one day
 hr. min.

Immediate cause of death Cardiovascular disease
 Duration

9. Birthplace Shannon Co. mo. 0
(City, town, or county) (State or foreign country)

Due to Severe Case of Influenza
 Due to
 Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation

Major findings: Of operations 131a
 Of autopsy
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business
 12. Name Mathie G. Hurt
 13. Birthplace Maryland 1
(City, town, or county) (State or foreign country)
 14. Maiden name Mathie G. Muligene
 15. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant O. O. Woodland
 (b) Address Salem, mo.

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?

17. (a) Burial (b) Date thereof 8-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Cedar Grove

18. (a) Signature of funeral director Hobart Franklin
 (b) Address Salem, mo.

23. Signature H. G. Dillard (M. D. or other)
 Address Salem Date signed 8-9-44

19. (a) 8-9-44 (b) Jos. W. Mc Cardy
(Date received local registrar) (Registrar's signature)

1177

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 5,

District File Number 844 446

Date Filed 8-25-44

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 J. H. Holloway
Licensed Embalmer No. 3643
P. O. Address Creba, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 57

Registration District No. 100 Primary Registration District No. 3018

1. PLACE OF DEATH:
(a) County DeWitt
(b) City or town Salem
(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 _____ 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 Mary Francis Woodland
(b) If veteran, name war _____ (c) Social Security No. _____

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 _____ years

7. Birth date of deceased Sept 9 1960
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER } 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) 8-9-64 (b) J. W. McHenry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept year 1964 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 _____
Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTAL

