

FILED AUG 28 1944

Registration District No. **29** Primary Registration District No. **4200** Registrar's No. **36**

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

1. PLACE OF DEATH:
 (a) County **Greene**
 (b) City or town **Ash Grove Mo**
(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)
 In this community **Most of Life**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Greene**
 (c) City or town **Ash Grove**
(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 **Anna Catherine Woods**
 3. (b) If veteran, name war..... 3. (c) Social Security No.....
 4. Sex **Female** / 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased **7 9 6 1884**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **7**
 year **1944** hour **6** minute **0** P.M.
 21. I hereby certify that I attended the deceased from **June 14** 19 **44** to **July 7** 19 **44**
 that I last saw her alive on **July 7** 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Generalized systemic toxemia.
 Due to **Secondary carcinoma of the liver.**
 Due to **Primary gastric carcinoma**
 Other conditions.....
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy **refused**

Duration
24 hr

8. AGE: Years Months Days If less than one day
60 11 12 hr. min.
 9. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
 10. Usual occupation **House Keeper**
 11. Industry or business.....
MOTHER { 12. Name **Not Known**
 13. Birthplace **Not Known**
(City, town, or county) (State or foreign country)
 14. Maiden name **Not Known**
MOTHER { 15. Birthplace **Not Known**
(City, town, or county) (State or foreign country)
 16. (a) Informant **Dee Woods**
 (b) Address **Ash Grove**
 17. (a) **Burial** (b) Date thereof **July 12 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: **Ash Grove Cemetery**
 18. (a) Signature of funeral director **Morris D. Leiman**
 (b) Address **Ash Grove Mo**
 19. (a) **7-12-44** (b) **J. B. Birch**
(Date received local registrar) (Registrar's signature)

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?
(Specify type of place)
 While at work?..... (e) Means of injury.....
 23. Signature **Home F. Matz**
(Name of physician)
 Address **Ash Grove, Mo** Date signed **7-12-44**

RECEIVED

Greene County Health Office,

County File Number 44-8-65

Date Filed 8/25/44

RECEIVED

TO THE

OFFICE

7505

1944

WORKING

1944

1944

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 Maude D. Morris

Licensed Embalmer No. 2055

P. O. Address Ash Grove 570

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.