

FILED SEP 9 1944

State File No. \_\_\_\_\_

Registration District No. 147

Primary Registration District No. 5551

Registrar's No. 75

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains, Missouri Rt. 3  
(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 20 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell

(c) City or town West Plains, MO. Rt. 3  
(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 Jas. Stumbaugh Woods

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 21  
year 1944 hour 12 minute 15 A. M.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Francis E. Woods

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased 9-4-62  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-1 to 7-25, 1944, that I last saw him alive on 7-15, 1944, and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral thrombosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation Farmer

Major findings: gza

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Hugh Woods

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

14. Maiden name Delilah Jackson

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Francis Woods

(b) Address West Plains, Mo. Rt. 3

17. (a) B (b) Date thereof 7-23-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Union Grove

18. (a) Signature of funeral director Robertsons

(b) Address West Plains, Missouri

19. (a) 8/10-44 (b) Sailor  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature E. A. Beach (M. D. or other) \_\_\_\_\_  
Address W. Mo. Date signed 8-2-44

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

46  
0  
0

RECEIVED

District Health Officer No. 5,  
District File Number 944470  
Date Filed 9-8-44

**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 *H. D. Roberts*

Licensed Embalmer No. 3437

P. O. Address *West Lane*

**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.**