S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 27 1944

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11221

Primary Registration District No. 2000

Registrar's No. 889

1. PLACE OF DEATH:

(a) County: GREENE

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

(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks (Specify whether years, months or days)

In this community 51 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39

(c) City or town: Springfield,
(If outside city or town limits, write "RURAL")

(d) Street No.: 1307 Meadowmere
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Margrett A. Woods

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

3. (c) Social Security No.: Unknown

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: W. W. Woods

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

7. Birth date of deceased: March (Month) 13, (Day) 1858 (Year)

8. AGE: Years 86 | Months 8 | Days 23 | If less than one day ___ hr. ___ min.

9. Birthplace: Belfort, (City, town, or county) Pennsylvania (State or foreign country)

10. Usual occupation: In Home

11. Industry or business:

FATHER
12. Name: Harvey Hoy
13. Birthplace: Belfort, (City, town, or county) Penna. (State or foreign country)

MOTHER
14. Maiden name: Katherine Hartman
15. Birthplace: Belfort, (City, town, or county) Penna. (State or foreign country)

16. (a) Informant: Mr. W. W. Woods

(b) Address: Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 / 8 / 44 (Month) (Day) (Year)

(c) Place: burial or cremation: Eastlawn Cemetery

18. (a) Signature of funeral director: Alma Lohmeyer Funeral Home

(b) Address: Springfield, Missouri

19. (a) 12-8-44 (Date received local registrar) (b) O. W. Hawley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 6, year 1944 hour 6:55 minute P. M.

21. I hereby certify that I attended the deceased from July, 1944 to 12/6/44, 19__; that I last saw her alive on 12/6/44, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of rectum	1 yr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Fractured rt. femur	1 mo

Major findings: Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: J. D. Lemmon (M. D. or other) M. D.

Address: Springfield, MO Date signed 12/8/44

(Licensed Embalmer's Statement on Reverse Side)

NOV 14 1948

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 Lewis G. Schaaf

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

JAN

State File No. _____

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 889

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield
(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 years, months or days)
In this community _____

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: Margrett A. Woods
3. (b) If veteran, name war _____
3. (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: March 13 (Month) (Day) _____ (Year)
8. AGE: Years 86 Months 8 Days _____ If less than one day: hr. _____ min.
9. Birthplace: _____ (City, town, or county) Penn (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER
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) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	

Other conditions: Fractured neck of femur
(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): Accident
(b) Date of occurrence: 11/3/44
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In the home (Specify type of place)
While at work? No (e) Means of injury: A fall
23. Signature: J. B. Lemmon (M. D. or other) md
Address: Springfield, Mo. Date signed 1/2/45

SUPPLEMENTARY

MAR 20 1945

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41221