

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

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X35497

FILED JAN 20 1945
Registration District No. 59

Primary Registration District No. 4097

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
306 Green St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 6 months (Specify whether years, months or days)
In this community: 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: C Camden 15
(c) City or town: ?
(If outside city or town limits, write "RURAL")
(d) Street No.: ?
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Rufus Ephland Wood
3. (b) If veteran name war:

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 10 year 1945 hour 2 minute 10 A.M.
21. I hereby certify that I attended the deceased from Dec. 1 1944 to Jan 10 1945

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife: Deceased 6. (c) Age of husband or wife if alive: 7 years
7. Birth date of deceased: Oct (Month) 6 (Day) 1869 (Year)

that I last saw him alive on Jan 10 1945 and that death occurred on the date and hour stated above.
Immediate cause of death: Chronic Nephritis
Atherosclerosis
Hypertension

3. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>3</u>	<u>4</u>	hr. min.

Due to: Hypertension
Due to:

9. Birthplace: TENN (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer retired 23 yrs.

Other conditions (Include pregnancy within 3 months of death): None
Major findings: None
Of operations: None
Of autopsy: no

MOTHER FATHER
12. Name: Theopalis Wood
13. Birthplace: TENN
14. Maiden name: Mary Moffett
15. Birthplace: TENN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)

16. (a) Informant: Robert Wood
(b) Address: Harrisonville Mo
17. (a) Burial (b) Date there: Jan 12-45
(c) Place: burial or cremation: Camden Co. Mo.
18. (a) Signature of funeral director: William B. ...
(b) Address: Harrisonville Mo
19. (a) Jan 11, 1945 (b) Margaret Valle
(Date received local registrar) (Registrar's signature)

(c) Where did injury occur?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work:

23. Signature: Dr. E. B. ... (M. D. or other) 90
Address: Harrisonville Mo Date signed: 1/10-45

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 Floyd Otterson.....

Licensed Embalmer No. 3920.....

P. O. Address Harrisonville.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1954

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(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 MO (b) County Camden
(c) City or town Roach
(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 Rufus E. Wood
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January 1945 year. 1945 day _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

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 _____ years
7. Birth date of deceased Oct 6
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days _____ If less than one day _____ min.

9. Birthplace _____ (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) _____ (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) _____ (b) Margaret Valle
(Date received local registrar) (Registrar's signature)

Duration _____
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 _____

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

SUPPLEMENTARY

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