

FILED APR 10 1945 28

Registration District No. 5465

Registrar's No. 260

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Rural, N. Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.F.D. #4 Box 638 1
(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 **GREENE**
(c) City or town **Rural, SPRINGFIELD - N. Campbell Twp.**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. #4 Box 638**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.....

3. (a) PRINT **JAMES GARFIELD WOOD**
FULL NAME

MEDICAL CERTIFICATION

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **493-16-5048**

20. DATE OF DEATH: Month **MARCH** day **26**
year **1945** hour **12** minute **55 P.M.**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **DAISY WOOD** 6. (c) Age of husband or wife if alive **UNK. years**
7. Birth date of deceased **SEPT. 3, 1880**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Mar 24/45**
19... to **March 26, 1945**
that I last saw him alive on **Mar 25**, 19...
and that death occurred on the date and hour stated above.

8. AGE: Years **64** Months **6** Days **23** If less than one day
hr. min.

Immediate cause of death **Cerebral Hemorrhage 2 days**
Due to **the cardio-vascular disease**
Due to.....

9. Birthplace **CHRISTIAN @ MO. I.**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **RETIRED TIRE REPAIRMAN**

PHYSICIAN

11. Industry or business **TIRE REPAIRING**

Major findings: Of operations **93d**

12. Name **STEPHEN W. WOOD**

Of autopsy.....

13. Birthplace **UNK. TENN. I**
(City, town, or county) (State or foreign country)

14. Maiden name **LEZZIE CRAIG**

15. Birthplace **UNK. UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edna A. King**

(b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **3/29/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenbawn**

18. (a) Signature of funeral director **J. W. Kingner MO.**

(b) Address **Springfield, Mo.**

19. (a) **3-27-45** (b) **S. W. Handley**
(Date received local registrar) (Registrar's signature)

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 **Arthur D. Krueger** (M. D. or other) **MD**
Address **400 1/2 E. Court St.** Date signed **3/27/45**

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

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 *Max Rhodes*
Licensed Embalmer No. *4071*
P. O. Address *Springfield,*

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.

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