

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16173**

FILED MAY 16 1945

Registration District No. _____

Primary Registration District No. 4005

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Rosendale
(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)
In this community 60 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town Rosendale
(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

ELIAS WOOD

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MD 5. Color or race W 6. (a) Single, widowed, married, divorced M
(b) Name of husband or wife MARY WADE WOOD 6. (c) Age of husband or wife if alive 85 years
7. Birth date of deceased Oct 8 - 1855
(Month) (Day) (Year)

8. AGE: Years 89 Months 5 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER
12. Name JOEL BAILEY WOOD
13. Birthplace un known
(City, town, or county) (State or foreign country)
14. Maiden name ELIZABETH
15. Birthplace un known
(City, town, or county) (State or foreign country)

16. (a) Informant Warner Wood

(b) Address Bolckow mo

17. (a) _____ (b) Date thereof 4-8-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bolckow

18. (a) Signature of funeral director E. B. Breit

(b) Address 8 Evans mo

19. (a) 4-6-45 (b) J. H. Fitchman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 5 year 1945 hour 6 minute _____ A.M.

21. I hereby certify that I attended the deceased from 3 - 18 1945 to 4 - 5 1945
that I last saw him alive on 4 - 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 weeks

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations gno

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 W. Logan Wood (M. D. or other) _____

Address Bolckow mo Date signed 4-5-45

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

RECEIVED
District Health Officer No. 111
District File Number
Date Filed

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 E. C. Breit
Licensed Embalmer No. 2650
P. O. Address Savannah 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.