

FILED JUN 26 1945

State File No.

Registration District No. 128

Primary Registration District No. 1000

Registrar's No. 482

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: Sprgld. Baptist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days  
(Specify whether  
In this community 3 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 445 S. Main  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Byron Woodward  
(b) If veteran, name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 14  
year 1945 hour 12 minute 15 p.m.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife UNK. 6. (c) Age of husband or wife if alive Dec - years  
7. Birth date of deceased March 18, 1865  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4/24/1945 to 6/14/1945  
that I last saw him alive on 6/13/1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 2 Days 26  
If less than one day hr. min.

Immediate cause of death Carcinoma duodenum Duration 3 mos  
Due to 46c

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

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

10. Usual occupation Farmer  
11. Industry or business \_\_\_\_\_  
12. Name Smith Woodward  
13. Birthplace UNK. Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Terissa Smith  
15. Birthplace UNK. Kentucky  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant E.R. Woodward  
(b) Address 445 S. Main Springfield  
17. (a) Burial (b) Date thereof 6/16/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Richland, Mo.  
18. (a) Signature of funeral director H.H. Lohmeyer  
(b) Address Springfield, Mo.  
19. (a) 6-15-45 (b) C. E. Feller  
(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 C. E. Feller (M. D. or other) \_\_\_\_\_  
Address Springfield Mo Date signed 6/14/45

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

DEC 18 1945

JUN 28 1945

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 Walter E Hamilton

Licensed Embalmer No. 3808

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.

X