No. 2
—5-43
5-17-39
X36671

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

State File No. 30832

FILED OCT 1 1945

Registration District No. 160 Primary Registration District No. 5592 Registrar's No. 224

1. PLACE OF DEATH
(a) County Jefferson
(b) City or town Herculaneum Jonchim
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 0
(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 Missouri (b) County Jefferson 50
(c) City or town Herculaneum 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lou Gladys Wood
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Fem
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept (Month) 20 (Day) 1869 (Year)

8. AGE:

Years	Months	Days	If less than one day
75	11	10	hr. min.

9. Birthplace Fayette Co. (City, town, or county) Ohio (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name Eli Wood
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Martha Hyre
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Bert Evans
(b) Address Herculaneum Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cemetery
18. (a) Signature of funeral director Fink Und. Co.
(b) Address Festus Mo.
19. (a) Sept. 2, 1945 (Date received local registrar) (b) Virginia Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1945 hour 12 minute 5 A.M.
21. I hereby certify that I attended the deceased from Aug, 1940, to Aug 30, 1945, that I last saw her alive on Aug 29, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	5 days
Due to Hypertension	6 years
Due to	
Other conditions Carcinoma left breast (Include pregnancy within 3 months of death)	3 yrs

Major findings:
Of operations
Of autopsy 50

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 Emmett Jenn MD (M. D. or other)
Address Herculaneum, Mo Date signed 9/1/45

1359

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number.....
Date Filed 9-28-45

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 Eleanor Prince

Licensed Embalmer No. 3403

P. O. Address Testus M

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.

No. 2B
—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mil Oct

Registration District No. 160 Primary Registration District No. 5592 Registrar's No. 224

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town Herculaneum Joachim Twp
(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 (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 Lou G. Wood
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 20 (Day) 1869 (Year)

8. AGE: Years 75 Months 11 Days 10 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)
10. Usual occupation Housework
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) Virginia Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 30 year 1945 hour 0 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.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

30832