

FILED OCT 17 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3033

1. PLACE OF DEATH:

(a) County LACLEDE  
(b) City or town LEBANON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: WALLACE HOSPITAL  
(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 ALWAYS years, months or days)

3. (a) PRINT FULL NAME MARY ELIZABETH WOOD  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F / 1 5. Color or race W  
6. (a) Single, widowed, married, divorced WIDOW  
6. (b) Name of husband or wife HENRY J. WOOD  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased APR 19 - 1876 (Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 11 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace LACLEDE CO MO (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name LEVI LILLARD  
13. Birthplace LACLEDE CO MO (City, town, or county) (State or foreign country)  
14. Maiden name MACE DONIA DOSIER  
15. Birthplace MO (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Geo. M. Thomas  
(b) Address LEBANON MO

17. (a) BURIAL (b) Date thereof SEPT 2-45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON

18. (a) Signature of funeral director PALMER'S  
(b) Address LEBANON MO

19. (a) Sept 18, 1945 (b) Geo. H. Zankbueger (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE  
(c) City or town LEBANON  
(If outside city or town limits, write "RURAL")  
(d) Street No. CATLIN AVE  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 30 year 1945 hour 8 minute 25 AM.  
21. I hereby certify that I attended the deceased from 8/25 1945 to 8/30 1945 that I last saw her alive on 8/29 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia right  
Due to Cerebral hemorrhage  
Due to Cardiovascular renal disease  
Other conditions fractured left hip at time of cerebral  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
PHYSICIAN \_\_\_\_\_

22. If death was due to external causes, give 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)  
(b) Means of injury \_\_\_\_\_  
23. Signature James A. Hope (M. D. seal)  
Address Lebanon, Mo Date signed 9/7/45

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

Received .....

Laclede County Health Unit

File No. 9-45-122

Date Filed 10/16/45

SECUR.

**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 *R. Palmer*

Licensed Embalmer No. 1161

P. O. Address Lebanon 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.**

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Jehans  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Mary E. 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 wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: Apr (Month) 17 (Day) 19 (Year)

8. AGE: Years 69 Months 4 Days \_\_\_\_\_ (less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER, FATHER

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 \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1945 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 8/25/45

(c) Where did injury occur? Houston, Laclede Co, Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
at home, fall of stroke

While at work? yes (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature James R. Hope (M. D. or other) \_\_\_\_\_

Address Jehans, Mo Date signed 10/31/45

SUPPLEMENTARY

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1 X43880

34066