

FILED DEC 7 1945

Registration District No. _____

Primary Registration District No. **3042**

Registrar's No. **77**

1. PLACE OF DEATH:
 (a) County Madison
 (b) City or town Fredericktown
 (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 about 30 years (years, months or days)

3. (a) PRINT FULL NAME: Charles E. Wood
 3. (b) If veteran, name war none
 3. (c) Social Security No. 1

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Minnie Wood 6. (c) Age of husband or wife if alive 73 years
 7. Birth date of deceased May 18 1870 (Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Iowa

11. Industry or business Painter & Paperhanger

12. Name unknown

13. Birthplace unknown (City, town, or county) _____ (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown (City, town, or county) _____ (State or foreign country)

16. (a) Informant Minnie C Wood

(b) Address Fredericktown, MO

17. (a) Burial (b) Date thereof Nov 29 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Methodist

18. (a) Signature of funeral director W. H. Holt

(b) Address Fredericktown, MO

19. (a) 11-29-45 (Date received local registrar) (b) Therence Hicks (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Madison
 (c) City or town 1237 Maple (If outside city or town limits, write "RURAL")
 (d) Street No. Fredericktown, Mo. (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 25 year 1945 hour 8:25 minute P. M.

21. I hereby certify that I attended the deceased from Apr. 20 1942 to Nov. 25 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Senile Debility

Due to _____
 Due to _____

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

Major findings: Of operations _____
 Of autopsy 1624

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 Keith L. Hull (M.D. or other) D.O.
 Address Fredericktown, Mo. Date signed 11-26-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

District Health Officer No. 4
District File Number 1245-1375
Date Filed 12-6-45

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 _____

John H. Holt

Licensed Embalmer No. 4264

P. O. Address Fredricktown, Va

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. 206

Primary Registration District No. 3042

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Fredricks town
(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)

3. (a) PRINT FULL NAME Charles E. Wood

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 18 1945
(Month) (Day) (Year)

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

9. Birthplace Madison, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
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 _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Florence Ticker
(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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

37889