

S. No. M-5-42 7-5-17-39 X32873

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED DEC 6 1945

STANDARD CERTIFICATE OF DEATH

State File No. 37987

Registration District No. 298

Primary Registration District No. 4330

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie
(c) Name of hospital or institution Residence 1
(d) Length of stay: In hospital or institution 73 years
In this community 73 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town East Prairie
(d) Street No.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME ALMERA WOODS

3. (b) If veteran, name war
3. (c) Social Security No. none

4. Sex! Male 5. Color of race white
6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Rufus Woods
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased April 20 1869

8. AGE: Years 76 Months 4 Days 13

9. Birthplace Marshall Co. Ky.

10. Usual occupation House wife

11. Industry or business

12. Name James McBride

13. Birthplace Unknown Ky.

14. Maiden name Nancy Beard

15. Birthplace Unknown Ky.

16. (a) Informant Rufus Woods

(b) Address East Prairie, Mo.

17. (a) Burial (b) Date thereof 9-4-45

(c) Place: burial or cremation Oakwood

18. (a) Signature of funeral director Richards Undertaker

(b) Address East Prairie Mo.

19. (a) 12-1-45 (b) G. S. Harper

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3 year 1945 hour 2 minute 30 P.M.
21. I hereby certify that I attended the deceased from June 1944 to Sept 3 1945
that I last saw her alive on July 10 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma Duration 3 or 4 yrs

Due to:
Due to:

Other conditions
Major findings:
Of operations
Of autopsy
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature J. S. Martin (M. D. or other)
Address East Prairie Date signed 12-7-45

11220

Mo

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

RECEIVED

District Health Office No. 2,

District File Number

12-45-3336

Date Filed

12-4-45

RECORDED

FILE

DEC 11 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

L. S. Hedgpeth

Licensed Embalmer No.

3803

P. O. Address

New Madrid, 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. 218

Primary Registration District No. 4330

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town East Prairie
(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 Almeda Woods

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.....

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

7. Birth date of deceased Apr 20
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 1 If 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) (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) (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..... 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 Cancer Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy..... 55

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—MARK A PERMANENT RE...

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

37987