

No. 2  
-8-43  
5-17-39  
K37823

State File No. \_\_\_\_\_

**FILED** JAN 3 1946  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3020

Registrar's No. 119

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Washington  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hospital 0  
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution. 6 hours  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin

(c) City or town Catasissa  
(If outside city or town limits, write "RURAL")

(d) Street No. RFD #1  
(If rural, give location)

(e) Citizen of foreign country?  (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bob Woodland

3. (b) If veteran, name war unknown

3. (c) Social Security No. none

4. Sex M 5. Color or race white

6. (a) Single, widowed, married, divorced unknown

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased unknown  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22  
year 1945 hour \_\_\_\_\_ minute 3:30 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to Dec 21 1945

that I last saw him alive on Dec 21  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
about 70 yrs hr. \_\_\_\_\_ min. 9

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

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

11. Industry or business Letter carrier

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 (b) Date thereof 12/29/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pacific 270

18. (a) Signature of funeral director P. J. Shebes  
(b) Address Parkway Mo

19. (a) 12/3/45 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

Immediate cause of death myocardial failure

Due to Pneumonia

Due to Senility

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

Major findings:  
Of operations

Of autopsy

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

(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)

(c) Means of injury \_\_\_\_\_

23. Signature G. S. Puffer (M.D. or other) P.D.  
Address Pacific 270 Date signed Dec 22 1945

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

MOTHER FATHER

1469

(Licensed Embalmer's Statement on Reverse Side)

**RECEIVED**  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 1-2-46

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**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 *Geo. L. Phelps*  
Licensed Embalmer No. 3008  
P. O. Address Pacific, 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. *116*

Primary Registration District No. *202*

1. PLACE OF DEATH:

- (a) County *Franklin*
- (b) City or town *Washington*  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:  
*St. Francis Hospital*  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution *6 hr.*  
(Specify whether

In this community  
years, months or days

3. (a) PRINT FULL NAME *Bob Woodland*

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 *unk*

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

7. Birth date of deceased *unk*  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
*about 70* \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(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) \_\_\_\_\_  
(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 \_\_\_\_\_ Day *22*  
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 \_\_\_\_\_

Due to *Labar Pneumonia*

Due to *before*

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

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

Of autopsy *108*

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

Duration

*Six*

*one wk*

*before*

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

41143