

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6425

State File No. _____
Registrar's No. 28

Registration District No. 200 Primary Registration District No. 3041

1. PLACE OF DEATH:
(a) County Macon Co.
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Samaritan Hosp. O
(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 Bobie Dean Wood
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 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: Jan 10 1946
(Month) (Day) (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 10 min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Raymond Wood
13. Birthplace Yarrow Mo
(City, town, or county) (State or foreign country)

14. Maiden name Cordele Dowell
15. Birthplace New Cambria Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Raymond Wood
(b) Address New Cambria Mo

17. (a) Burial (b) Date thereof Jan 11 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Cambria Cemetery

18. (a) Signature of funeral director H.P. Hilliland

(b) Address New Cambria

19. (a) Feb 5 1946 (b) Ruth Mcneely
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Macon 61
(c) City or town New Cambria (Rural) 0
(If outside city or town limits, write "RURAL")
(d) Street No. 6 Miles North of New Cambria 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
year 1946 hour 1 pm minute _____ M.

21. I hereby certify that I attended the deceased from Jan 10 1946 to Jan 10 1946
that I last saw him live on Jan 10 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia neonatorum
Due to incomplete development
Due to Premature birth

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

Major findings:
Of operations 159
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 R.P. Snow (b) or other _____
Address Macon MO Date signed 2-4-46

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

MOTHER FATHER

185

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 3-46-41

Date Filed MAR 11 1946

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.....

Licensed Embalmer No.....

P. O. Address.....

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.