

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Salem
(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 45 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dent
(c) City or town Salem
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Olcott Oliver Woodland

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Mary J. Woodland 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Feb 16 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 0 If less than one day hr. _____ min. _____

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

10. Usual occupation Stone Mason

11. Industry or business Stone Mason

12. Name Daniel Woodland

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

14. Maiden name Callahan

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

16. (a) Informant Charles Woodland

(b) Address Salem, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-46
(Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove

18. (a) Signature of funeral director John G. Beathan

(b) Address Salem, Mo

19. (a) 7-18-46 (Date received local registrar) (b) on on cert on D by M... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1946 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 7-2-46 19____, to 7-10-46 19____; that I last saw him alive on 7-10-46 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction

Duration thruway

Due to _____

Due to _____

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

Major findings: Of operations none

Of autopsy none 930

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 B. E. Goff (M. D. or other) MD

Address Salem, Mo Date signed 7/19/46

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

1-33

RECEIVED

District Health Officer No. 5,

District File Number

846454

Date Filed

8-7-46

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

Max L. Wanfel

Licensed Embalmer No.

4170

P. O. Address

Salem, 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.