

S. No. 2  
 DM-5-43  
 v. 5-17-39  
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
 BUREAU OF THE CENSUS  
**FILED NOV 1 1946 STANDARD CERTIFICATE OF DEATH**

State File No. **32716**  
 Registrar's No. **252**

Registration District No. **38** Primary Registration District No. **3006**

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

**1. PLACE OF DEATH:**  
 (a) County **Boone**  
 (b) City or town **Columbia**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Granau Convalescent Home**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **1 Week**  
(Specify whether  
 In this community **26 Years**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **Boone** **10**  
 (c) City or town **Columbia** **2**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **12 McBaine Ave.** **4**  
(If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **JESSIE FARRAR WOODS**  
 3. (b) If veteran, name war **None** 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife **W.W. Woods** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **1 - 26 - 1872**  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month **Oct.** day **17**  
 year **1946** hour **10** minute **35 P.M.**  
 21. I hereby certify that I attended the deceased from **April 15**  
**1946** to **Oct 17** 19**46**  
 that I last saw her alive on **Oct 17** 19**46**  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years **74** Months **8** Days **21** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death: **Arterial hemorrhage**  
 Due to **arterio sclerosis**  
 Due to **arterial hypertension**  
 Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace **Huntsville Missouri**  
(City, town, or county) (State or foreign country)  
 10. Usual occupation **At Home**

Major findings: **83A**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**MOTHER** { 11. Industry or business \_\_\_\_\_  
**FATHER** { 12. Name **Scott Malone**  
 13. Birthplace **Randolph County Missouri**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Laura Burton**  
 15. Birthplace **Huntsville Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Noah Martin**  
 (b) Address **12 McBaine Ave., Columbia, Mo.**

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? **U**

17. (a) **Burial** (b) Date thereof **10-20-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Parron Funeral Service**  
 (b) Address **Columbia, Mo.**

While at work? **Yes** (Specify type of place) \_\_\_\_\_  
 (a) Means of injury \_\_\_\_\_  
 23. Signature **W. E. Palmer** (M. D. or other)  
 Address **Columbia, Mo.** Date signed **11/17/46**

19. (a) **10-24-46** (b) **Mrs. R. E. Palmer**  
(Date received local registrar) (Registrar's signature)

**RECEIVED**  
District Health Officer No. 9,  
District File Number  
~~Date Filed 10/29/46~~

**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..... *TOM Mc Harg* .....

Licensed Embalmer No..... *4067* .....

P. O. Address..... *Columbia, 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.