

U.S. No. 2
FORM-2-43
Rev. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 22 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33992

Registration District No. 170

Primary Registration District No. 3033

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Laclede

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community entire life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede ⁵³

(c) City or town Lebanon ¹
(If outside city or town limits, write "RURAL")

(d) Street No. 315 Van Buren St. ²
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) ⁰
If yes, name country _____

3. (a) PRINT FULL NAME George Washington Wood

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6 year 1946 hour 5 minute P. M.

4. Sex male 5. Color or race W

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

6. (b) Name of husband or wife Alice Wood

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

7. Birth date of deceased Sept. 12 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-10-1946 to 10-6-1946 that I last saw him alive on 10-2- and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

78 0 24 hr. min.

Immediate cause of death Cerebral hemorrhage Duration 1 month

9. Birthplace Des Moines Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

Due to _____

Due to _____

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

11. Industry or business _____

12. Name John Quincy Wood ⁷

13. Birthplace unknown ⁷
(City, town, or county) (State or foreign country)

14. Maiden name Malinda Greens

15. Birthplace unknown ⁴
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Q3P

Of operations _____

Of autopsy _____

16. (a) Informant Best Wood

(b) Address Lebanon Mo.

17. (a) Burial (b) Date thereof 10-8-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery, Lebanon

18. (a) Signature of funeral director W.E. Holman

(b) Address Lebanon Mo.

19. (a) Oct 11, 1946 (b) Dr. Frankberger
(Date received local registrar) (Registrar's signature)

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? 0

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature R. E. Harrell (M. D. or other) MD

Address Lebanon Mo. Date signed 10-9-46

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Received 10-17-46
Laclede County Health Unit
File No. 9-46-114
Date Filed 10-21-46

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 Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon 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.