

Registration District No. 207

Primary Registration District No. 5706

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Rural - Jefferson
(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 16 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Harvey Woodruff

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 Married
6. (b) Name of husband or wife Emma Nauger 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Dec 28 1871
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 29 If less than one day hr. min.

9. Birthplace Crawford County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name John Woodruff
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Armstrong
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant John Woodruff
(b) Address Belle - Mo.

17. (a) Burial (b) Date thereof March 2 - 1977
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Staggs Chapel

18. (a) Signature of funeral director Staggs
(b) Address Belle - Mo.

19. (a) 3-5-47 (b) Pauline Howard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries 63
(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27 1947
year 9 hour 10 minute 7 M.

21. I hereby certify that I attended the deceased from Jan 1 1946 to Jan 1 1947
that I last saw him alive on Jan 26 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 5 months of death)

Major findings: Of operations _____

Of autopsy no

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 4
(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?

(Specify type of place) (e) Means of injury 0

23. Signature O. K. Jones (M. D. or other) _____
Address Belle Date signed Mar 4 1977

~~Date Filed~~
~~3-10-47~~
~~District File Number~~
~~10-10-47~~

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 Chester Sisson

Licensed Embalmer No. 4178

P. O. Address Bland

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.