

S. No. 2
1-12-45
7. 5-17-39
X47070

FILED MAY 5 1947

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **391**

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2221 N. Missouri. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 33 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene **39**
(c) City or town Springfield **2**
(If outside city or town limits, write "RURAL")
(d) Street No. 2221 N. Missouri **6**
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) **0**
If yes, name country.

3. (a) PRINT FULL NAME Flora Dell Wood

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thomas B. Wood 6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased September 14, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 7 13 hr. min.

9. Birthplace Marysville Ohio /
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name William Westlake
13. Birthplace Marysville Ohio /
(City, town, or county) (State or foreign country)

14. Maiden name Mills
15. Birthplace Marion Co. Mo. /
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas D. Wood
(b) Address Springfield Mo. 4-29-1947

17. (a) Burial (b) Date thereof 4-29-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield Mo.

19. (a) 4-30-47 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1947 hour 12 minute 10 A. M.

21. I hereby certify that I attended the deceased from 10 April
1947 to 27 April 1947
that I last saw her alive on 25 April 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of the rectum
Due to Carcinoma of the rectum **2 yrs.**
Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None
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 O

23. Signature D. M. Klingner (M. D. or other) M.D.
Address Springfield, Mo. Date signed 28 April 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.....

.....
Licensed Embalmer No. 4071

P. O. Address.....
Springfield

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.