

No. 2
12-45
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16405
State File No. _____
Registration District No. 11
Primary Registration District No. 402350
Registrar [Signature]

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Oscar D. Caywood

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 Widowed

6. (b) Name of husband or wife Mattie Caywood 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased December 20 1859
(Month) (Day) (Year)

8. AGE: Years 87 Months 3 Days 28
If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Isiac Caywood

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

14. Maiden name Not known

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

16. (a) Informant W. R. Caywood

(b) Address Exeter, Mo. R#

17. (a) Burial (b) Date thereof 4/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelgreen Cem.

18. (a) Signature of funeral director Wm. M. [Signature]
(b) Address Wheaton, Missouri

19. (a) May 2-1947 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1947 hour 4 minute _____ P. M.

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

Immediate cause of death Apparently a Heart Attack
Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence 4-18-47
(c) Where did injury occur? at home farm
(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 [Signature] (M.D. or other) _____
Address Mount Mo. Date signed 4-18-47

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6;

District File Number 47-528

Date Filed MAY 22 1947

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 Wm Morris Payne

Licensed Embalmer No. 3447

P. O. Address Wheaton, 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.