

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED AUG 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28445

Registration District No. 237

Primary Registration District No. 4353

Registrar's No. 68

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Gideon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Hopkins Clinic  
(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

3. (a) PRINT FULL NAME

Melitta Wood

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race w

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 8-3-47  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. <u>45</u> min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name EARNEST Wood

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

14. Maiden name Ada Fern Reed

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

16. (a) Informant Mr Earnest Wood

(b) Address Gideon Mo.

17. (a) Burial (b) Date thereof 9-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of general director family

(b) Address Gideon Mo.

19. (a) Aug 15 1947 (b) Mr Ernest Wood  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid  
(c) City or town Gideon  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 3  
year 1947 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from 8-3 1947 to 8-3 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure  
Prematurity

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 154  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature J. S. Hopkins (M. D. or other) \_\_\_\_\_  
Address Gideon, Mo. Date signed 8-12-47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 847-1102

Date Filed 8-18-47

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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.....

P. O. Address.....

**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.**