

FILED NOV 5 1947

Registration District No. _____

Primary Registration District No. 3012

Registrar's No. 163

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Veterans Administration Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 mos. 9 days
 (Specify whether
 In this community 10 mos. 9 days
 years, months or days)

3. (a) PRINT FULL NAME HERRINGTON, Woodson H.3. (b) If veteran, name war World War II 3. (c) Social Security No. 395-10-2496

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married
Separated
 6. (b) Name of husband or wife Margaret Herrington 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased June 17, 1909
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>4</u>	<u>5</u>	hr. _____ min.

9. Birthplace Glenwood, Arkansas
(City, town, or county) (State or foreign country)10. Usual occupation Cook11. Industry or business —12. Name Magnus Herrington13. Birthplace Saline County Arkansas
(City, town, or county) (State or foreign country)14. Maiden name Hanner Hendrick15. Birthplace Alabama
(City, town, or county) (State or foreign country)16. (a) Informant Hospital Records, Veterans Administration Hospital(b) Address Excelsior Springs, Missouri17. (a) Removal (b) Date thereof 10-22-47
(Burial, cremation, or disposal) (Month) (Day) (Year)(c) Place: burial or cremation Wadsworth, Kansas18. (a) Signature of funeral director HOPE FUNERAL HOME(b) Address Excelsior Springs, Missouri19. (a) 10-22-47 (b) Caroline Hutchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Garland 999
 (c) City or town Hot Springs 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. 509 Park Ave. 0
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) 20
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22
year 1947 hour 4 minute 00 A M21. I hereby certify that I attended the deceased from December 13, 1946 to October 22, 1947.
that I last saw him alive on October 22, 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary reinfection type, far advanced, active, severe symptoms Duration unknown
~~XXXX~~ Broncho pleural fistula right

Due to _____

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

Major findings: Of operations _____

Of autopsy NO AUTOPSY PERFORMED

PHYSICIAN _____

Underline the cause of 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? _____ (Specify type of place)

While at work? _____ (e) Means of injury — 023. Signature S. C. Stoeff (M. D. or other) M.D.Address Veterans Administration Hosp signed 10-22-47
Excelsior Springs, Mo.

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 11-4-47

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

J. Amos

Licensed Embalmer No.

3296

P. O. Address

Exp Springs 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.