

Registration District No. 27

Primary Registration District No. 5119

State File No. _____

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Centralia R
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 6 mo. years, months or days

3. (a) PRINT FULL NAME Clarence Edward Wood

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m.
6. (b) Name of husband or wife Laura Mabel Wood 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 23, 1872 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>0</u>	<u>16</u>	hr. _____ min. _____

9. Birthplace Old Stream Ont. Canada (City, town, or county) (State or foreign country)

10. Usual occupation Minister (7th Day Advent)

11. Industry or business _____

12. Name John Wood
13. Birthplace Canada (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth March
15. Birthplace Canada (City, town, or county) (State or foreign country)

16. (a) Informant Wife
(b) Address Centralia, Mo.

17. (a) Burial (b) Date thereof Nov. 12, 1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo.

18. (a) Signature of funeral director John J. Smith
(b) Address Centralia, Mo.

19. (a) Nov. 20 - 1947 (b) Maud Mc Bride (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Boone 10
(c) City or town Centralia (If outside city or town limits, write "RURAL") 0
(d) Street No. R.F.W. St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 9
year 1947 hour 3 minute 04 P.M.

21. I hereby certify that I attended the deceased from 11-5-47 19____ to 11-9-47 19____
that I last saw him alive on 11-9-47 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 4 days.

Due to Hypertension

Due to Atherosclerosis

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

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(c) 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 Dr. Baker (M.D. or other)
Address Centralia, Mo. Date signed 11-15-47

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

MOTHER FATHER

RECEIVED
District Health Officer No. _____
District File Number _____
Date Filed DEC 2 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

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.