

No. 2
-1/47
5-17-39

Registration District No. **131948**

Primary Registration District No. **4534**

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

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Caledonia
(c) Name of hospital or institution: 1
(d) Length of stay: In hospital or institution _____ (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Washington
(c) City or town Caledonia
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

In this community _____ years, months or days

3. (a) PRINT FULL NAME Mary J. Wood
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 27
year 1947 hour 8 minute 20 A.M.

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 5 1945
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 5, 1945 to Dec. 27, 1947.
that I last saw him alive on Dec. 26, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza
Duration 3 days

8. AGE: Years Months Days If less than one day
2 4 22 hr. _____ min.

Due to _____
Due to _____

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

Other conditions Hypothyroidism
(Include pregnancy within 3 months of death) Widow

10. Usual occupation None

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
Underline the cause of which death should be charged statistically.

MOTHER FATHER
11. Industry or business none
12. Name Walter Wood
13. Birthplace Grandwater Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Earna Ralston
15. Birthplace Cassville Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Wood
(b) Address Caledonia Mo.

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

17. (a) Burial (b) Date thereof 12-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Caledonia Mo.

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

18. (a) Signature of funeral director Mr. Luther Spink
(b) Address Peters Mo.

(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 _____

19. (a) 1. 6-47 (b) Mrs. Ella J. White
(Date received local registrar) (Registrar's signature)

23. Signature Ben W. Bull (M. D. or other) M.D.
Address Donon, Mo. Date signed 12-31-47

RECEIVED

Health Officer No. 4

File Number 148-45

Date Filed 1-12-48

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 *Murphy L. Spaulds*

Licensed Embalmer No. *4236*

P. O. Address *State River, 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.