

Registration District No. 1948

Primary Registration District No. 2000

Registrar's No. 124

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Springfield Baptist  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether  
In this community 60 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene  
(c) City or town Springfield Fair Grove  
(If outside city or town limits, write "RURAL")  
(d) Street No. RT. 2  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7  
year 1948 hour 7 minute 50 a.m.  
21. I hereby certify that I attended the deceased from Feb 5  
1948, to Feb 7 1948  
that I last saw him or alive on Feb 6 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia  
Duration 1 wk

Due to  
Due to

Other conditions Hypertensive  
(Include pregnancy within 3 months of death)  
Heart disease

Major findings: Bronch. collapsed frags.

Of operations  
Of autopsy 932

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 (Specify type of place) Means of injury  
23. Signature Guy D. Callaway MD  
Address Springfield Mo Date signed 2/7/48

3. (a) PRINT FULL NAME Addie Wood  
3. (b) If veteran, name war no  
3. (c) Social Security No. no

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife W. D. Wood  
6. (c) Age of husband or wife if alive 81 years  
7. Birth date of deceased May 22 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 8 14 br. min.

9. Birthplace French Lick Ind.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name John Hobson

13. Birthplace French Lick Ind.  
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Lashbrooks

15. Birthplace French Lick Ind.  
(City, town, or county) (State or foreign country)

16. (a) Informant W. D. Wood

(b) Address Fair Grove

17. (a) Burial (b) Date thereof 2-10-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Comfort

18. (a) Signature of funeral director J. W. Klingner

(b) Address 424 E. Comm. Springfield

19. (a) 2-10-48 (b) W. S. Handley MD  
(Date received local registrar) (Registrar's signature)

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

MOTHER: FATHER:

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.