

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 5 1948

Registration District No. 312

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6276

State File No. 11329

Registrar's No. 9

1. PLACE OF DEATH:
Worth

(a) County: Sheridan (rural-Union Township)
(b) City or town: (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)

(d) Length of stay: In hospital or institution (Specify whether

In this community: Life
years, months or days)

3. (a) PRINT FULL NAME Sharon Louise Woodward

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

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: November 15 1947
(Month) (Day) (Year)

8. AGE: Years 0 Months 3 Days 29 If less than one day hr. min.

9. Birthplace: Maryville Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation:

11. Industry or business:

12. Name: Charles A. Woodward

13. Birthplace: Kearney Nebraska
(City, town, or county) (State or foreign country)

14. Maiden name: Bonnie Jean Turner

15. Birthplace: Sheridan Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Harry Turner

(b) Address: Sheridan, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-16-1948
(Month) (Day) (Year)

(c) Place: burial or cremation: Sheridan Mo. Cemetery

18. (a) Signature of funeral director: Frank C. Dwyer

(b) Address: Grant City, Mo.

19. (a) March 22-1948 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Worth

(c) City or town: Rural (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: March day: 14
year: 1948 hour: 6 minute: 02 A.M.

21. I hereby certify that I attended the deceased from Jan 1948 to March 1948

that I last saw her alive on: 13 March 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhagic Purpura of newborn

Due to:

Due to:

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

Major findings: Of operations:

Of autopsy:

Duration

PHYSICIAN

Underline the cause to 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?

While at work? (Specify type of place) Means of injury:

23. Signature: Frank B. Madison, M.D. (Dr. or other)

Address: Grant City, Mo.

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Arch C. Dumble

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.