

FILED AUG 4 1948

Registration District No. **145**

Primary Registration District No. **5566**

Registrar's No. **12**

1. PLACE OF DEATH:

(a) County **Iron**  
 (b) City or town **Belleview**  
 (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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Iron**  
 (c) City or town **Belleview**  
 (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 \_\_\_\_\_

3. (a) PRINT FULL NAME **Clifford Edward Woods**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **male** 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 **August 6 1946**  
 (Month) (Day) (Year)

8. AGE: Years **1** Months **11** Days **21** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **none**

11. Industry or business \_\_\_\_\_

12. Name **Claude Woods**

13. Birthplace **Glover Missouri**  
 (City, town, or county) (State or foreign country)

14. Maiden name **Beulah Copeland**

15. Birthplace **Reynolds Co. Mo.**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Beulah Woods**

(b) Address **Belleview Missouri**

17. (a) **burial** (b) Date thereof **7-28-48**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Belleview Mo.**

18. (a) Signature of funeral director **White Funeral Home**

(b) Address **Ironton Missouri**

19. (a) **July 28, 1948** (b) **Mrs. Elizabeth Logan**  
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **27**  
 year **1948** hour **8** minute **30 AM.**

21. I hereby certify that I attended the deceased from **by inquest duties** 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** ✓  
 Duration \_\_\_\_\_

Due to **malnutrition**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy **none**

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) (e) Means of injury **3**

23. Signature **Chas. Hampton** Coroner  
 Address **Annapolis Mo.** Date signed **7-27-48**

ADDITIONAL SUPERVISORY RECOMMENDATION

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

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

**RECEIVED**

District Health Officer No. 4

District File Number 848-972

Date Filed 8-2-48

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**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 Paul J. White

Licensed Embalmer No. 3012

P. O. Address Greenville, S.C.

**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.

Registration District No. 145

Primary Registration District No. 5566

1. PLACE OF DEATH:

(a) County Iron  
(b) City or town Bellevue  
(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)

3. (a) PRINT FULL NAME

Clifford E Woods

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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 6 (Month) (Day) (Year)

8. AGE: Years 11 Months 11 Days \_\_\_\_\_ (If less than one day, hr. min.)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1948 Year \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Lobar Pneumonia

Due to \_\_\_\_\_

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:

(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) (e) Means of injury \_\_\_\_\_

23. Signature Chad Hampton (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-23016

11/19  
11/19  
11/19