

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26915**

FILED AUG 19 1948  
Registration District No. **7175**

Primary Registration District No. **55-883648**

Registrar's No. **181**

1. PLACE OF DEATH:  
(a) County **Lawrence**  
(b) City or town **Wentworth RFD**  
(c) Name of hospital or institution: **Rural 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **same**  
In this community **50 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO** (b) County **Jasper**  
(c) City or town **Rural 49**  
(d) Street No. **Saracoye Lumph 0**  
(If outside city or town limits, write "RURAL")  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Wm Woodridge**  
3. (b) If veteran, name war **✓**  
3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **8** day **1st**  
year **1948** hour **1100** minutes **P** M.  
21. I hereby certify that I attended the deceased from **April 12**  
\_\_\_\_\_, 1948, to **Aug 1**, 1948  
that I last saw him alive on **July 31**  
and that death occurred on the date and hour stated above.

4. Sex **MO** 5. Color or race **wh**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Kate** 6. (c) Age of husband or wife if alive **57** years  
7. Birth date of deceased **Oct 22, 1888**  
(Month) (Day) (Year)

Immediate cause of death **Membr.** Duration \_\_\_\_\_  
Due to **Chronic glomerular nephritis**  
Due to **Carcinoma of bladder + urinary organ** 1 yr  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
**59 9 9** hr. min.

9. Birthplace **Madison Co MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

MOTHER FATHER  
11. Industry or business **Farmer**  
12. Name **Ben Woodridge**  
13. Birthplace **unknown 9**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Jenny Bishop**  
15. Birthplace **unknown 9**  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
52B

16. (a) Informant **Kate Woodridge**  
(b) Address **Saracoye MO**  
17. (a) **Burial** (b) Date thereof: **8-3-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Saracoye Lumph**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Jackson & Son**  
(b) Address **Saracoye MO**  
19. (a) **8-3-1948** (b) **L. B. Clinton MO**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **Skelline** (M. D. or other) **M.O.**  
Address **Saracoye MO** Date signed **8/2/48**

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

28-8-704

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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 me

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Kearney 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.**

Registration District No. 175

Primary Registration District No. 5648

Registrar's No. 75

1. PLACE OF DEATH: Lawrence  
 (a) County Lawrence  
 (b) City or town Wentworth  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Mt. Pleasant Hosp  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME Wm Wealdridge  
 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 \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Oct 22  
 (Month) (Day) (Year)

8. AGE: Years 59 Months 9 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 \_\_\_\_\_

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) Orsa Mc Math  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO (b) County Jasper  
 (c) City or town Barrow  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct Day 22 Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ above on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 D E Kelham (M. D. or other) \_\_\_\_\_

Address Lawrence, Mo

SUPPLEMENTARY

MOTHER FATHER

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

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

1948  
S-26915