FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36323

FILED NOV 29 1948

Registration District No. 143

Primary Registration District No. 5561

Registrar's No.

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Siloam Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Home
(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 Mo (b) County Howell 46
(c) City or town Siloam Springs 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Beverly Jean Woolf
3. (b) If veteran, name war
3. (c) Social Security No.

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

8. AGE: Years | Months | Days 5 | If less than one day hr. min.

9. Birthplace Siloam Springs Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Infant
11. Industry or business
FATHER
12. Name Henton Lewvern Woolf
13. Birthplace Rector Mo
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Loretta Jane Collins
15. Birthplace Siloam Springs Mo
(City, town, or county) (State or foreign country)
16. (a) Informant Henton Lewvern Woolf
(b) Address Siloam Springs Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 11-21-48 (Month) (Day) (Year)
(c) Place: burial or cremation Siloam Springs
18. (a) Signature of funeral director none
(b) Address
19. (a) Nov 20-1948 (Date received local registrar) (b) Beatrice Cook (Registrar's signature) 387

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20th
year 1948 hour 11 minute 00 p. M.
21. I hereby certify that I attended the deceased from birth 11/5/48
19 to Nov. 19 1948
that I last saw her alive on Nov. 19 1948
and that death occurred on the date and hour stated above.

Immediate cause of death ~~Spina Spida~~ Sp. Spina Bifida — Duration 4 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

157B

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? 2
(Specify type of place)
While at work? (e) Means of injury
23. Signature Virgil J. Bailey (M. D. or other) DO.
Address West Plains Mo. Date signed 11/20/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 11-23-48
District Health Officer No. 5,
District File Number 11-48-723
Date Filed 11-24-48

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.....

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.

2B
-45
43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 14 143 Primary Registration District No. 5561 Registrar's No. 83

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Silvan Springs
(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 years, months or days)

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

3. (a) PRINT FULL NAME Beverly J. Woolf

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan (Month) 16 (Day) 1948 (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Jan. 14 1949 (Date received local registrar) (b) Marshall Ballard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 20
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive 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

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-36323