

FILED JUN 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18318

BIRTH NO. _____ REG. DIST. NO. 337 PRIMARY REG. DIST. NO. 4499 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY Shelby		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Shelby	
b. CITY OR TOWN Shelbina		c. CITY OR TOWN Shelbina	
c. LENGTH OF STAY (in this place) 14Yrs		d. STREET ADDRESS (If rural, give location) Walnut St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) George	b. (Middle) Olon	c. (Last) Wood	4. DATE OF DEATH (Month) (Day) (Year)
				May 22nd 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 15th 1880	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months 7 Days 7	IF UNDER 24 HRS. Hours 7 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY g " "	11. BIRTHPLACE (State or foreign country) Madison Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William H Wood	13b. MOTHER'S MAIDEN NAME Elle M Lenhart	14. NAME OF HUSBAND OR WIFE Maude S Wood	Shelbina
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mrs Maude S Wood	ADDRESS Shelbina Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Occlusion		INTERVAL BETWEEN ONSET AND DEATH 6 hr.
	- ANTECEDENT CAUSES Chronic Hypertension		
	DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Hypertension			420)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 21, 1949**, to **May 22, 1949**, that I last saw the deceased alive on **May 22, 1949**, and that death occurred at **11:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or title) A R Garrison J D	23b. ADDRESS Shelbina Mo	23c. DATE SIGNED May 23, 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/24/49	24c. NAME OF CEMETERY OR CREMATORY Madison Cemetery	24d. LOCATION (City, town, or county) (State) Madison Mo
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DATE REC'D BY LOCAL REG. May 24-49	REGISTRAR'S SIGNATURE Ada Garrison	25. FUNERAL DIRECTOR'S SIGNATURE Million & Barkelew	ADDRESS Shelbina Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*General Commission
Charles Roberts*

RECEIVED

District Health Officer No. 10

District File Number 5-48-94

Date Filed MAY 31 1949

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 _____
Charles Roberts

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *Denny C. Barklow*

Licensed Embalmer No. 3835

P. O. Address Phillips, 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.