

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

20382

1. PLACE OF DEATH

County Linn
Township Marshall
City _____ (No. _____)

Registration District No. 796
Primary Registration District No. 3058

File No. _____
Registered No. 87
St. _____ Ward _____

2. FULL NAME

Zachariah Daniel Wood

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julia C Wood

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>64</u>	<u>5</u>	<u>29</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cartersville
(STATE OR COUNTRY) Virginia

10. NAME OF FATHER J. D. Wood

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Thomas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)

14. INFORMANT Geo. W. Smith
(Address) Marshall mo

15. FILED 5-28 19 29 Mrs. John H. McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 19 29

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 29 to May 20 29
that I last saw him alive on May 20 29, and that death occurred, on the date stated above, at 11:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
80H

97 (duration) yrs. mos. 1 ds.
CONTRIBUTORY (SECONDARY) Arterial Sclerosis

(duration) 0 yrs. mos. ds.

18. 74 WERE THERE DISEASES CONTRACTED IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

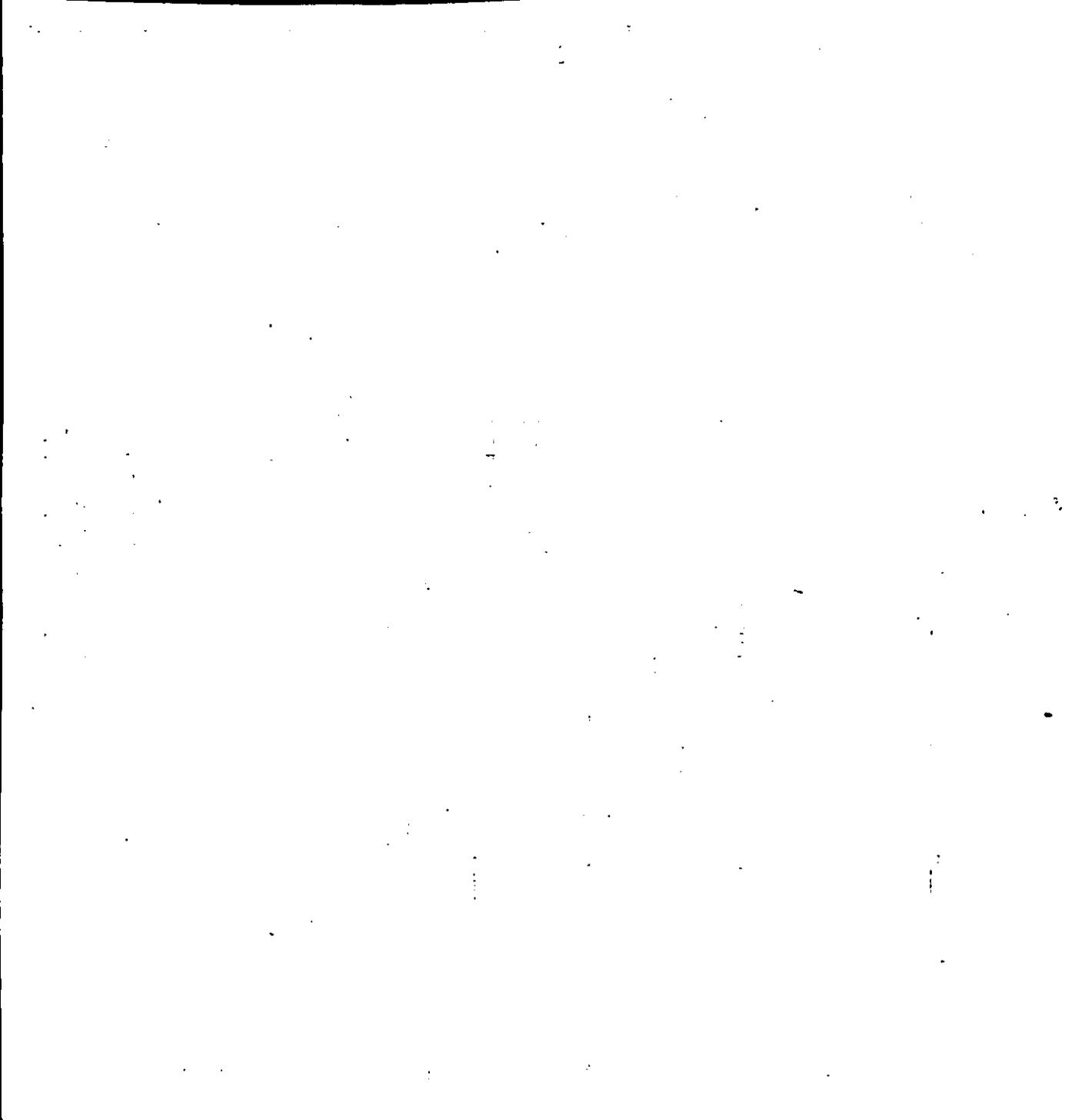
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Harrison M. D.

574 .19 29 (Address) Marshall mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cartersville W. Va. DATE OF BURIAL 5/29 19

20. UNDERTAKER L. R. Vandiver ADDRESS Marshall mo



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Saline Registration District No. 296 File No. _____
 Township Marshall Primary Registration District No. 6039 Registered No. 87
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Jochariah Daniel Wood
 (a) Residence. No. _____ St. _____ Ward. Wood
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
M

4. COLOR OR RACE
W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Wed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>69</u>			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 5-28-29 Mr. John H. McKeire REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____, a/c on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

5-22-1929

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1929
20382