

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

Do not use this space.

40128

**1. PLACE OF DEATH**

County *Miller*  
Township *Epworth*  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. *564*  
Primary Registration District No. *3759*

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

*Myrtle Edna 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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF *Lyman Wood*  
(OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 7 1900*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*30 7 2*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) *Miller Co Mo*

10. NAME OF FATHER *John Adolph Heister*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Miller Co Mo*

12. MAIDEN NAME OF MOTHER *Lula Affroy*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Hamilton Co Mo*

14. INFORMANT *Jim J. Heister*  
(Address) \_\_\_\_\_

15. FILED *12/5 1930* REGISTRAR *J. H. Kamm*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-9 1930*

17. I HEREBY CERTIFY, That I attended deceased from *12-9 1930* to *12-9 1930* that I last saw her alive on *12-9 1930* and that death occurred, on the date stated above, at *9:30 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:  
*Haemorrhage of brain*

CONTRIBUTORY (SECONDARY) *Leakage of heart* (duration) yrs. mos. ds. *Don't know* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *927*  
IF NOT AT PLACE OF DEATH *8211*

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) *W. H. Koons* M. D.  
19 (Address) *Suscumbia 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 *Woodland* DATE OF BURIAL *12-9 1930*

20. UNDERTAKER *Chapman* ADDRESS *Chapman*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

*JAN 20 1931*



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