

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.

MAR 24 1934

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

Do not use this space.

9464

1. PLACE OF DEATH

51

County Johnson
Township Rose Hill
City..... (No..... St..... Ward.....)

Registration District No. 437
Primary Registration District No. 557

File No.....
Registered No.....

2. FULL NAME

Robert A. Wooldridge

(a) Residence, No..... St..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary Wooldridge</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan-8-1851</u>		
7. AGE	YEARS <u>83</u>	MONTHS <u>1</u>
	DAY <u>26</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....	
	10. Date deceased last worked at this occupation (month and year).....	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
FATHER	13. NAME <u>J. B. H. Wooldridge</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>	
MOTHER	15. MAIDEN NAME <u>Sarah Lacy</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>	
17. INFORMANT (ADDRESS) <u>Mrs Lillie Ingles</u> <u>Bronville mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Clearfork Cemetery</u> DATE <u>Mar 8</u> , 19 <u>34</u>		
19. UNDERTAKER (ADDRESS) <u>J. T. Johnson</u> <u>Holden mo.</u>		
20. FILED <u>Mar 9th</u> , 19 <u>34</u> <u>Minna M. Coleman</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

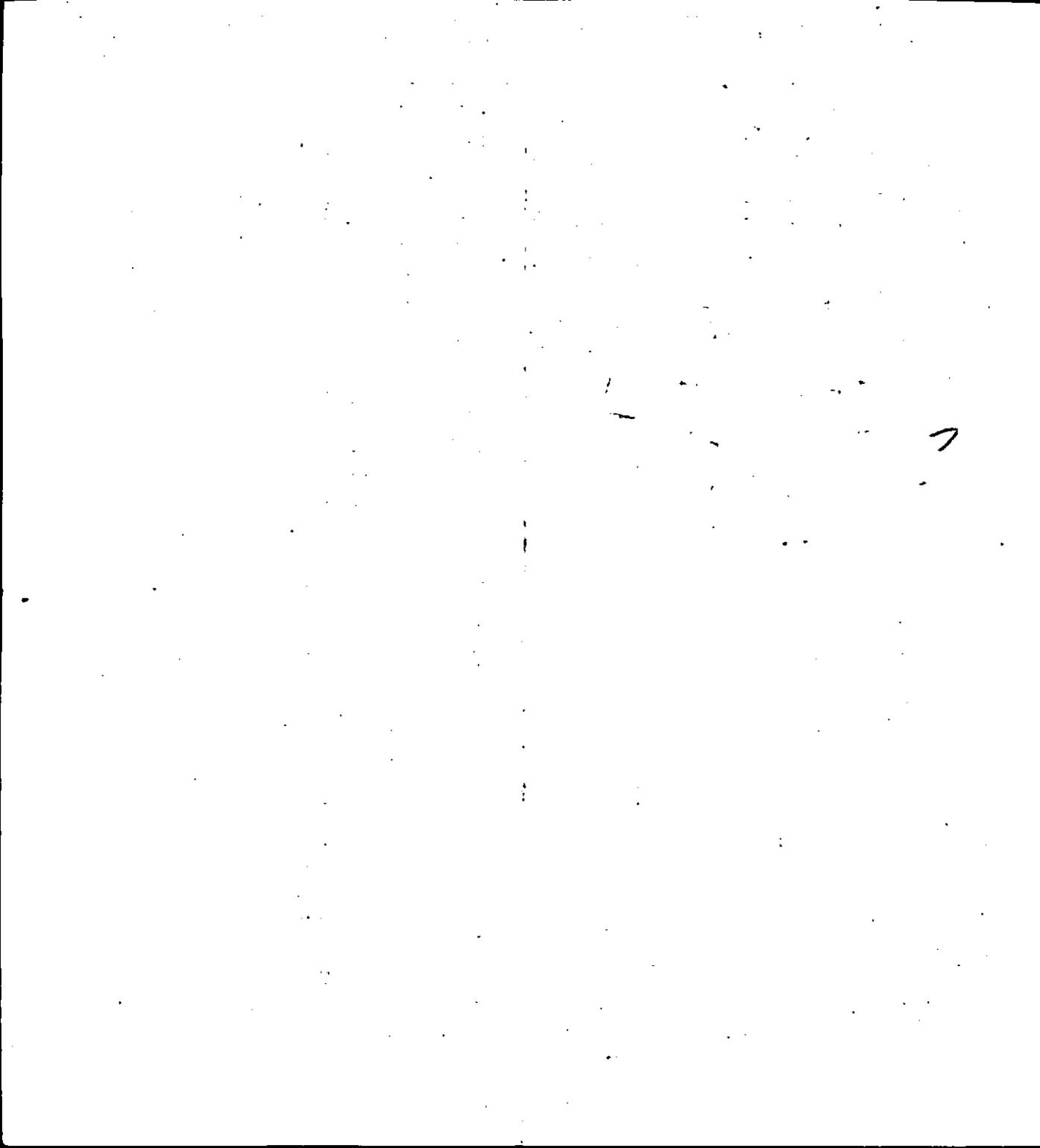
21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 6, 1934

22. I HEREBY CERTIFY, That I attended deceased from Sept, 1933, to Mar, 1934
I last saw him alive on Feb 16, 1934. Death is said to have occurred on the date stated above, at 2:30 P. m.
The principal cause of death and related causes of importance were as follows:
Paralysis
of Winnifred
1341
Other contributory causes of importance:
1341

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) J. T. Sheffer, M. D.
(Address) Laurel mo



Johnson

9464

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Robert A. Wooldridge
Who died at _____ on Mar 16-1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, married, widowed or divorced: M

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Paralysis
Paralysis caused by Cerebral hemorrhage

Other contributory causes of importance Uremic poison ^{caused by} prostatitis
Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician J. T. Whelton, L. T. ...

Address of physician ... 111 ...

> Signature of Registrar _____ Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 437
Primary Reg. Dist. No. 5594

Very truly yours,
E. T. McGaugh

Special Agent.

S-9464 (1934)