

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

40426
Do not use this space.

1. PLACE OF DEATH
 (a) County Oregon ² Registration District No. 632
 (b) Township Thayer Primary Registration District No. 4382
 (c) City Thayer (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 4-316 Amanda E. Woodridge
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe **4. COLOR OR RACE** wh **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Woodridge
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-26-1859
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80- 0 24-
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
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) Kentucky
13. NAME Carroll
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
17. INFORMANT (NAME) (ADDRESS) Rice Woodridge Thayer Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Thayer Mo 11/21-39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Geo Carr Thayer Mo
20. FILED Nov-20 1939 George Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-20 1939
22. I HEREBY CERTIFY, That I attended deceased from 9-1 1939 to 11-20 1939
 I last saw him alive on 11-19 1939 Death is said to have occurred on the date stated above, at 5:45 p.m.
 The principal cause of death and related causes of importance were as follows:
Chronic Nephritis
Chronic Myocarditis
 Date of onset _____
 Other contributory causes of importance: Scurvy
 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) W. Cooper M. D.
 (Address) Thayer Mo

Cooper

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.

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 1239472

Licensed Embalmer No.....

Date Filed 12/3/39

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, above space should be left blank.