

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.

MAY 13 1940

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

14945
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 322
 (b) Township Jackson Primary Registration District No. 5447A
 or Fair Grove
 (c) City Fair Grove (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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

Relia C. Womack
 (a) Residence, No. Fair Grove R 21 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov-24-1862</u>		
7. AGE	YEARS	MONTHS
	<u>77</u>	<u>4</u>
		DAYS
		<u>28</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housekeeper</u>	
	9. Industry or business in which work was done, as 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>Fair Grove Mo</u>		
FATHER	13. NAME <u>Henderson Womack</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>N. C.</u>	
MOTHER	15. MAIDEN NAME <u>Mary Murrell</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>N. C.</u>	
17. INFORMANT <u>W. C. Womack</u> (ADDRESS) <u>Fair Grove Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Cedar Bluff</u> DATE <u>4-22-40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>L. B. Jones</u> <u>Buffalo Mo</u>		
20. FILED <u>Mar 25 1940</u> <u>Willan Barnes</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-21-1940

22. I HEREBY CERTIFY, That I attended deceased from 5/1, 1940 to 4/21, 1940
 I last saw h. ev alive on 4/18, 1940 Death is said to have occurred on the date stated above, at 8 P m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of sigmoid
 Date of onset _____

Other contributory causes of importance: 46

Name of operation None Date of _____
 What test confirmed diagnosis? None Was there an autopsy? No

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? No
 If so, specify _____
 (Signed) Chas. M. J. [Signature] M. D.
 Address Springfield Mo

RECEIVED

Greene County Health Office,

County File Number 40-5-20

Date Filed 5-6-40

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.

Signed.....

Licensed Embalmer No.....

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.