No. 2
-13-40
-17-39
I X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40675

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 10446

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede

(c) City or town Lebanon N.R.
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Lavina Wood

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Nov. (Month) 30 (Day) 1880 (Year)

8. AGE: Years 60 Months 0 Days 19 If less than one day hr. min.

9. Birthplace Laclede Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 0

MOTHER FATHER

12. Name John Dawson

13. Birthplace Missouri (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Frank Wood

(b) Address Lebanon, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/19/40 (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) DEC 19 1940 (Date received local registrar) (b) J. H. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1940 hour 11 minute 20 a.m.

21. I hereby certify that I attended the deceased from Dec 9, 1940 to Dec 19, 1940 that I last saw her alive on Dec 19, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	
Due to: Arteriosclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: none	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work?

(e) Means of injury

23. Signature Joseph E. Carney (M. D. or other) MD

Address 5215 Frisco Bldg. Date signed 12-19-40

(Licensed Embalmer's Statement on Reverse Side)

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. 1861

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.