

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42564

JAN 10 1941

State File No.

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

1040

1. PLACE OF DEATH

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **Surge Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene**
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **1330 N. Clay Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **GEORGE W. WOODS.**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color of race **White** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **EDITH L. WOODS** 6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased. **June 17 1881**
(Month) (Day) (Year)

8. AGE: Years **59** Months **6** Days **12** If less than one day _____ hr. _____ min.

9. Birthplace **Unknown Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Barber**

11. Industry or business **Barbering**

12. Name **George W. Woods**

13. Birthplace **Unknown Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Emma Goodman**

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

16. (a) Informant **Edith L. Woods**

(b) Address **Springfield, Mo**

17. (a) **Burial** (b) Date thereof **12-31-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenlawn**

18. (a) Signature of funeral director **W. T. Walsh**

(b) Address **Springfield, Mo**

19. (a) **12-31-40** (b) **W. E. Haudley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **29**
year **1940** hour **12** minute **15** P. M.

21. I hereby certify that I attended the deceased from **Dec 15**
19**40**, to **Dec 29** 19**40**
that I last saw him alive on **Dec 29** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to **Cerebral hemorrhage**

Due to **arterio sclerosis**

Other conditions: **✓**
(Include pregnancy within 3 months of death)

Major findings: **✓**
Of operations **✓**

Of autopsy **✓**

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

(a) Accident, suicide, or homicide (specify) _____

(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?
At work

While at work? **✓** (Specify type of place)

(e) Means of injury _____

23. Signature **W. T. Walsh** (M. D. or other) **✓**

Address **Springfield, Mo** Date signed **12/30/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

William M. [Signature]

Licensed Embalmer No.....

4071

P. O. Address.....

Springfield

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, fact should be so stated above.

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