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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FEB 17 1941
Registration District No. 477

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3219
Registrar's No. 8

Primary Registration District No. 4286

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

1. PLACE OF DEATH:
(a) County Lewis
(b) City or town Canton
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) /
(d) Length of stay: In hospital or institution 2 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John W. Woodson

3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Male
5. Color or race Black
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Drusilla Hawkins
6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased March 26 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 3
If less than one day hr. min.

9. Birthplace Waterloo Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER {
12. Name Allen Woodson
13. Birthplace Louisiana
(City, town, or county) (State or foreign country)
14. Maiden name Mary Robinson
15. Birthplace Mary Robin Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs John W. Woodson
(b) Address Canton, Mo.

17. (a) Burial (b) Date thereof Jan. 31, 41
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Carl W. Buckley
(b) Address Canton, Mo.

19. (a) Feb. 1, 1941 (b) P. W. Jennings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lewis
(c) City or town Canton
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29
year 1941 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from Aug. 5
1940 to Jan. 29, 1941
that I last saw him alive on Jan. 21, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of abdomen

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration
1 yr
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) _____

(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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature P. W. Jennings (M. D. or other) D
Address Canton Mo. Date signed 1-30-41

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10-10-1935

RECEIVED DISTRICT HEALTH OFFICER NO. 10

RECEIVED

District Health Officer No. 10

District File Number 2-41-274

Date Filed FEB 13 1941

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 Earl H. Buckley

Licensed Embalmer No. 2615

P. O. Address Canton, Mo.

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3219

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 477

Primary Registration District No. 4216

Registrar's No.

1. PLACE OF DEATH:

(a) County Leury's
(b) City or town Anton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 _____ (b) County _____
(c) City or town _____ (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 John H. Woodson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race Black 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 74 Months 10 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (City, town, or county) _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) _____ (Registrar's signature)

DECEASED CERTIFICATION

20. DATE OF DEATH: Month Jan day 29
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I last saw h. _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Abdomen of sigmoid
Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration 6 mos
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) _____
(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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

