FILED SEP 2 1942

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

27773
Do not use this space.

73 0 0

1. PLACE OF DEATH

(a) County Newton — Registration District No. 243

(b) Township Franklin — Primary Registration District No. 4364 — Registered No. 37

(c) City or Stella, — (d) Street No. 0 Cardwell Hospital 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 Thomas H. Woods

(a) Residence, No. St. 0

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male 0	W	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Fannie Woods

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 18th 1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	87	6	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming

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) Tenn. /

FATHER

13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn. /

MOTHER

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn. /

17. INFORMANT Ida Duvall (ADDRESS) Prague Okla.

18. BURIAL, CREMATION, OR REMOVAL

PLACE True Love Cem. DATE Aug. 16th 1942

19. FUNERAL DIRECTOR (NAME) Wm Morris Rogers (ADDRESS) Wheaton, Mo.

20. FILED Aug. 24 1942 Dana Gerstner *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 14 1942

22. I HEREBY CERTIFY, That I attended deceased from Aug 10 1942 to Aug 14 1942

I last saw him alive on Aug 14 1942. Death is said to have occurred on the date stated above, at 6 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocardial Insufficiency	8-1-42

Other contributory causes of importance: Senile Nephritis (?)

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) O. Cardwell, M. D.

(Address) Stella, Mo.

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 6,
District File Number 942-1282
Date Filed SEP 1 1942

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~~ .....
Wm Morris Pogue, Registered Apprentice No. .....
working under my personal supervision.

Signed Wm Morris Pogue

Licensed Embalmer No. 3842

P. O. Address Wheaton, Ill.

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

If this body is not embalmed, above space should be left blank.

2B
1-41
9288

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. 27773

Registration District No. 243 Primary Registration District No. 436 Registrar's No. 37

1. PLACE OF DEATH:
(a) County: Newton
(b) City or town: Stella
(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 years, months or days)
In this community .....

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) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Thomas H. Woods
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Fannie
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Jan (Month) 18 (Day) 1855 (Year)

8. AGE: Years 87 Months 6 Days 28 Of less than one day ..... hr. ..... min.

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

16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day ..... year 1942 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw him alive on ..... 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial heart failure	6-1-42
Due to:	
Due to:	
Other conditions: acute Nephritis (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy: 130

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: C. Cardwell (M. D. or other)
Address: Stella, Mo. Date signed .....

SUPPLEMENTARY