

No. 2
4-13-40
5-17-39
X231859

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25016

State File No. _____

FILED AUG 9 1943

Registration District No. 310 128

Primary Registration District No. 5465

Registrar's No. 571

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town RURAL SPRINGFIELD Campbell Sup.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 5 1/2 YR. 4 MO. 15 DAY (Specify whether years, months or days)

3. (a) PRINT FULL NAME

JOHN ROSCOE WOOD

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MIDGE WOOD

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased MARCH 1 1892

(Month) (Day) (Year)

8. AGE:

Years 51 Months 4 Days 15
If less than one day hr. _____ min. _____

9. Birthplace

POLK CO. MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation

FARMER

11. Industry or business

FARMING

12. Name

W. D. WOOD

13. Birthplace

Ind. 1
(City, town, or county) (State or foreign country)

14. Maiden name

ADDIE HOBSON

15. Birthplace

Ind 1
(City, town, or county) (State or foreign country)

16. (a) Informant

Mrs. John P Wood

(b) Address

Springfield Mo. R#1

17. (a)

Burial (b) Date thereof July 18-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Mt Comfort Cem.

18. (a) Signature of funeral director

J. W. Withingner

(b) Address

Springfield, Mo.

19. (a)

7-17-43 (b) J. S. W. Handy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE
(c) City or town Rural Springfield Campbell Sup.
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #1
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 the year 1943 hour 12:30 minute _____ M.

21. I hereby certify that I attended the deceased from

7/16 1943 to 7/16/1943

that I last saw him alive on 7/16/1943 and that death occurred on the date and hour stated above.

Immediate cause of death

Brain hemorrhage Duration 6 hr

Due to Arterio Sclerosis
Hypertension

Due to _____

Other conditions

Hypertension (Include pregnancy within 4 months of death)

Major findings:

Of operations _____

Of autopsy _____

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. E. Feller (M. D. or other) _____
Address Springfield Mo Date signed 7/14/43

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

39
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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

J. B. Klingner

Licensed Embalmer No.

3358

P. O. Address

Springfield, Ma

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.