

Registration District No. 43

Primary Registration District No. 2007

Registrar's No. 179

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Toplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lucy Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Clay
(c) City or town M^cDougal
(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 Virginia Lee Woods

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 28 1936
(Month) (Day) (Year)

8. AGE: Years 7 Months 6 Days 22 If less than one day hr. _____ min. _____

9. Birthplace M^cDougal Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Mart Woods
13. Birthplace Sidney Ark.
(City, town, or county) (State or foreign country)
14. Maiden name Jewell Wood
15. Birthplace M^cDougal Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Mart Woods
(b) Address M^cDougal, Ark.

17. (a) B (b) Date thereof 5-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation East Oak Cemetery

18. (a) Signature of funeral director Lloyd Russell
(b) Address 2490 N. Ark

19. (a) 5-26-44 (b) Belle Trimmie
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
year 1944 hour 1:30 minute A M.

I hereby certify that I attended the deceased from May 14 1944 to May 20 1944
that I last saw him alive on May 20 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal hemorrhage Duration 10 days
Due to Splenic anemia 1 year

Other conditions _____ (Include pregnancy within 3 months of death) 75a

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? _____

(Specify type of place) _____ While at work? _____ (e) Means of injury _____
23. Signature V. S. Miller (M. D. or other) _____
Address Toplar Bluff, Mo Date signed 5/21/44

RECEIVED

District Health Office N

District File Number 644-8

Date Filed 6-14-8

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.....

P. O. Address.....

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.

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 179

Registration District No. 13

Primary Registration District No. 3007

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: July Lee Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether

In this community.....
years, months or days
(e) PRINT FULL NAME: Virginia Lee Wood
(f) If veteran, name war..... (g) Social Security No.....

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

8. AGE: Years Months Days If less than one day min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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) 6/18/44 (Date received local registrar) (b) Belle Kinn (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1944 hour 5 minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

(Immediate cause of death.....) Duration.....
Due to.....
Due to.....

Other conditions..... (Include pregnancy within 3 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)
(b) 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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

MOTHER FATHER

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