

FILED DEC 20 1946

Registration District No. **130**

Primary Registration District No. **54637**

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

1. PLACE OF DEATH:

(a) County **GREENE**

(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Strafford R.F.D. # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **all her life** (Specify whether years, months or days)

In this community **all her life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **Strafford R.F.D. # 2**
(If rural, give location)

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

3. (a) PRINT FULL NAME **MARY JOSIE WOOD**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **none**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Frank S. Wood**

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

7. Birth date of deceased **September 28, 1880**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **11th**
year **1946** hour **3:45 P.M.** minute _____ M. _____

21. I hereby certify that I attended the deceased from **Dec. 11, 1946** to **Dec. 11, 1946**
that I last saw her alive on **Dec. 11, 1946**
and that death occurred on the date and hour stated above.

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

66	2	13	hr. _____ min. _____
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Immediate cause of death **Cerebral Hemorrhage** Duration 4 hours

Due to _____

Due to _____

9. Birthplace **no record** **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business **None**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **83A**

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **Jona. Hill Akin**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. Eva Drake**

(b) Address **R.F.D. # 1, Strafford, Mo.**

17. (a) **BURIAL** (b) Date thereof **Dec-15-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Danforth Cemetery**

18. (a) Signature of funeral director **Fred G. Thieme**
Springfield, Missouri

(b) Address _____

19. (a) **Dec-14-46** (b) **James J. Grier**
(Date received local registrar) (Registrar's signature)

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? **no**

While at work? (Specify type of place) _____

(a) Means of injury _____

23. Signature **R. H. Fout** (M. D. or other)
Address **Strafford Mo.** Date signed **12/14/46**

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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..... *Ralph H. T. Meim*

Licensed Embalmer No. *Sp 3684*

P. O. Address *Springfield, Mo.*

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.