S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8051

FILED MAR 24 1947

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 342

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Knosky Nursing Home 1401 Jules Street (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Several months. (Specify whether years, months or days)
In this community Many years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph. (If outside city or town limits, write "RURAL")
(d) Street No. 1401 Jule Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Samuel Winter Woodruff.
3. (b) If veteran, name war No.
3. (c) Social Security No. None.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife not stated
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 3rd. (Day) 1865 (Year)

8. AGE: Years 81 Months 3 Days 28 If less than one day hr. min.

9. Birthplace Green Springs, Ohio. (City, town, or county) (State or foreign country)
10. Usual occupation Blacksmith.
11. Industry or business Railroad.
FATHER
12. Name Unknown.
13. Birthplace Unknown. (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown. (City, town, or county) Unknwon (State or foreign country)
16. (a) Informant Mrs Morehead
(b) Address Social Security Board.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director Mrs E. R. Tidenfaden
(b) Address 602 South 10th Street
19. (a) 3-13-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day first. year 1947 hour 4 minute AM---- M.
21. I hereby certify that I attended the deceased from Feb. 22, 1947, to Feb. 28, 1947 that I last saw him alive on Feb. 25, 1947. and that death occurred on the date and hour stated above.

Immediate cause of death coronary thrombosis Senility — Duration 1 hr. 5 yrs.
Due to chronic myocarditis Senile dementia — 1 hr.
Due to abrasions to scalp face from fall — 1 wk.
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) accident
(b) Date of occurrence February 22, 1947
(c) Where did injury occur? abrasion to scalp not the cause of death. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1401 Jule Nursing Home (Specify type of place)
While at work? no (e) Means of injury fall
23. Signature W. Teatheda (M.D. or other)
Address Kirkpatrick Bldg. Date signed 3/5/47.

382 (Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.

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 Mollie E. Sidenfaden Fox

Licensed Embalmer No. 4235

P. O. Address St. Joseph, 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.