

S. No. 2
M-5-43
7. 5-17-39
P 1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 17 1947
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21787

Registration District No. 257 Primary Registration District No. 4386 Registrar's No.

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Thayer
(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) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Oregon
(c) City or town Thayer
(d) Street No.
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Samuel Benton Wooldrige
3. (b) If veteran, name war. -- 3. (c) Social Security No. 702-03-8427

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, married.
6. (b) Name of husband or wife Lottie Wooldrige
6. (c) Age of husband or wife if alive. 65 years
7. Birth date of deceased April 26 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 - 13 hr. min.

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

10. Usual occupation Yardman
11. Industry or business Railroad

MOTHER FATHER
12. Name William H. Wooldrige
13. Birthplace Kentucky
14. Maiden name Susan Cormack
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant (b) Address Thayer, Mo.

17. (a) Burial (b) Date thereof 5/11/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Thayer Cem.

18. (a) Signature of funeral director (b) Address Thayer, Mo.

19. (a) 5-17-47 (b) Edith Cray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9
year 1947 hour 10 minute 03 A.M.
21. I hereby certify that I attended the deceased from 1947 to June 9, 1947
that I last saw him alive on May 9, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Bladder
Due to: Prostate Gland
Due to:

Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations: 52B
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) (c) Means of injury.
23. Signature: [Signature] (M. D. or D.O.)
Address: [Signature] Date signed: 5-16-47

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

RECEIVED

District Health Officer No. 8

District File Number 64 7309

Date Filed 6-16-47

JUN 18 1947

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.