

S. No. 2
M-5-43
5-17-39
X3667

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

FILED JUL 15 1948

Registration District No. **102**

Primary Registration District No. **5416**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Dunklin**

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

(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 _____)

In this community **Life** _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Dunklin 35**

(c) City or town **Arbyrd Mo. Rt. 1** _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) _____

(e) Citizen of foreign country? **No** _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Clipper W. Woods**

3. (b) If veteran, name war **X**

3. (c) Social Security No. **X**

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Stella Woods**

6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **Jan. 14 1900**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	48	4	8	hr. _____ min. _____

9. Birthplace **Coldwater Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Frank Woods**

13. Birthplace **Coldwater Mo. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Ida Bell Stevens**

15. Birthplace **Stoddard County Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Meda Wheeler**

(b) Address **Arbyrd Mo.**

17. (a) **Burial** (b) Date thereof **5-23-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Arbrd. Mo.**

18. (a) Signature of funeral director **Howard Und. Co.**

(b) Address **Leachville Ark.**

19. (a) **6-25-48** (b) **E. B. Harrison**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **22nd**
year **1948** hour **3.00** minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**

Due to **Hypertension**

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence **May 22nd 1948**

(c) Where did injury occur? **Arbrd Mo. Rt. 1**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? _____ (Specify type of place)

(e) Means of injury **3**

23. Signature **Allen A. Harrison** Coroner
Address **Henrett Mo.** Date signed **5-22-48**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Office No. 2,
District File Number 248-869
Date Filed 2-12-48

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 H. H. Howard
Licensed Embalmer No. 3959
P. O. Address Leachville Ark.

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.