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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 20 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40945

State File No.

Registration District No. 254

Primary Registration District No. 4386

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thayer
(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 years, months or days) 15 years

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

3. (a) PRINT FULL NAME Truman Lafayette Wood

3. (b) If veteran, name war --

3. (c) Social Security No. 500-10-2059

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Katie Wood

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased August 30 1891
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>11</u>	<u>10</u>	hr. min.

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

10. Usual occupation Farmer and Sawmill worker

11. Industry or business _____

MOTHER FATHER { 12. Name Tine Wood

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

14. Maiden name Cliton

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

16. (a) Informant T. L. Wood

(b) Address Thayer, Mo.

17. (a) Burial (b) Date thereof 8/11/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thayer Cem.

18. (a) Signature of funeral director Edward Carter

(b) Address Thayer, Mo.

19. (a) 9-3-48 (b) E. C. Cross
(Date received local registrar) (Registrar's signature) 4/1/48

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon

(c) City or town Thayer
(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 Aug. day 10
year 1948 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 5 1948 to Aug 10 1948
that I last saw him alive on Aug 10 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myelitis Duration 5 yrs.

Due to _____

Due to _____

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

Major findings: Of operations U

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)

(e) Means of injury 2

23. Signature John P. Ellison (M. D. or other) MD

Address Thayer Mo Date signed 9-1-48

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

X

RECEIVED 12-11-48
District Health Officer No. 5,
District File Number 1248774
Date Filed 12-13-48

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.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Jan36Registration District No. 254Primary Registration District No. 4386

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Oregon shayer
 (b) City or town _____
 (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 _____
years, months or days)3. (a) PRINT FULL NAME Juman L. Wood

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Aug 30
(Month) (Day) (Year)

8. AGE: Years 56 Months 11 Days 20 (If less than one day, hr. min.)

9. Birthplace Mich.
(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) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

15. (a) Signature of funeral director _____
 (b) Address _____

19. (a) 9-3-48 (b) Ella Cross
(Date received local registrar) (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 _____ Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

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 _____
 (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)
 (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

S-40945