S. No. 2
M—8-43
5-17-39
P1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21079

State File No.

FILED JUL 12 1945

Registration District No. 47

Primary Registration District No. 6022

Registrar's No. 40

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

1. PLACE OF DEATH:
(a) County: Ray
(b) City or town: Rayville, Mo. R. Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location) None
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: All His Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Ray
(c) City or town: Rayville Rural (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: William Preston Wood
3. (b) If veteran, name war: No
3. (c) Social Security No.: no
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: 9
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased: April 22 nd. 1870 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	2	3	hr. min.

9. Birthplace: Marshall, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: James Wood
13. Birthplace: Missouri. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Mergerette Hurshman
15. Birthplace: Missouri. (City, town, or county) (State or foreign country)
16. (a) Informant: Arthur Wood
(b) Address: Richmond, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-27 th. 45. (Month) (Day) (Year)
(c) Place: burial or cremation: Crowley ?Near RayvilleMo.
18. (a) Signature of funeral director: Brothers -Quest
(b) Address: Richmond, Mo.
19. (a) June 26 1945 (Date received local registrar) (b) Mrs Chas W Sheppard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1945 hour 8 minute 15 A M.
21. I hereby certify that I attended the deceased from June 10, 1945, to June 25, 1945
that I last saw him alive on June 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage, Left Hemiplegia — Duration
Due to: Essential Hypertension
Due to: Chronic Cardio Renal Vascular Disease
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy: None

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Otto E Buehner (M. D. or other)
Address: Lawson Mo. Date signed: June 26/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7/11/48

OCT 30 1951

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.

Brothers & Quest Funeral Home

Signed Louis Quest

Licensed Embalmer No. 4096

P. O. Address Richmond, 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.

S. No. 2B
5M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21079

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 40

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Rayville or Richmond Twp (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 ______ In this community ______ (Specify whether years, months or days)

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 ______

3. (a) PRINT FULL NAME Wm P. 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 Widowed
6. (b) Name of husband or wife ______ 6. (c) Age of husband or wife if alive ______ years
7. Birth date of deceased Apr (Month) 22 (Day) 70 (Year)
8. AGE: Years 75 Months 2 Days 3 If less than one day ______ hr. ______ min.
9. Birthplace ______ (City, town, or county) Mo (State or foreign country)
10. Usual occupation ______
11. Industry or business ______
FATHER 12. Name ______
13. Birthplace ______ (City, town, or county) ______ (State or foreign country)
MOTHER 14. Maiden name ______
15. Birthplace ______ (City, town, or county) ______ (State or foreign country)
16. (a) Informant ______
(b) Address ______
17. (a) ______ (Burial, cremation, or removal) (b) Date thereof ______ (Month) (Day) (Year)
(c) Place: burial or cremation ______
18. (a) Signature of funeral director ______
(b) Address ______
19. (a) ______ (Date received local registrar) (b) Mrs Chas W. Shepperd (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1945 hour ______ minute ______ M.
21. I hereby certify that I attended the deceased from ______, 19___, to ______, 19___;
that I last saw h___ alive on ______, 19___;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ______	
Due to ______	
Due to ______	
Other conditions ______ (Include pregnancy within 3 months of death)	
Major findings: Of operations ______	PHYSICIAN Underline the cause to which death should be charged statistically.
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? ______ (Specify type of place)
While at work? ______ (e) Means of injury ______
23. Signature ______ (M. D. or other)
Address ______ Date signed ______