DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

16356

State File No. 3

Registration District No. 887   Primary Registration District No. 6138   Registrar's No. 27

1. PLACE OF DEATH:
(a) County Texas County
(b) City or town Houston Mo Lynch (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 Two Weeks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town California (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Dareen Wood
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased March (Month) 3 (Day) 1873 (Year)
8. AGE: Years 67 Months 1 Days 27 If less than one day hr. min.
9. Birthplace Quincy Ill (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name W. H. Sells
13. Birthplace Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nora Sells
15. Birthplace Keokuk Iowa (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Willie Mayberry
(b) Address Houston Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 1, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Zion
18. (a) Signature of funeral director Jack Barnhill
(b) Address Cabool Mo
19. (a) May 2, 40 (Date received local registrar) (b) Julia Keeney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1 year 1940 hour 1:00 minute 00 P. M.
21. I hereby certify that I attended the deceased from April 30, 1940, to May 1, 1940
that I last saw her alive on May 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL APOPLEXY
Due to HYPERTENSIVE CARDIO-RENAL-VASCULAR DISEASE
Due to
Other conditions NERVOUS SHOCK
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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? No
(Specify type of place)
(f) While at work? No (e) Means of injury

23. Signature N. M. Dillman (M. D. or other) M.D.
Address Houston Date signed 5-1-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Helper Earl R. Bawlin, Registered Apprentice No. 627 working under my personal supervision.

Signed Jack Bawlin

Licensed Embalmer No. 627

P. O. Address California, Mo

RECEIVED
District Health Officer No. 5,
District File Number 540 5-25
Date Filed 5 14 40

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, above space should be left blank.

No. 2B
2-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16356

Registration District No. 883 Primary Registration District No. 6138 Registrar's No. 27

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Lynch
(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 Dasreen Wasreen Wood

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

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wd
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) (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) May 10 (Date received local registrar) (b) Julia Keeney (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) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
year 1940 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	
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:
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(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 L M Dillman (M. D. or other)
Address Houston Mo Date signed

SUPPLEMENTARY