

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4334

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4334

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days)

In this community as above

3. (a) PRINT FULL NAME Mrs. Mattie Woodward,

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife David F. Woodward,

6. (c) Age of husband or wife if alive 11 years

7. Birth date of deceased: 1 29 1865
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 8 16
If less than one day hr. min.

9. Birthplace: Mo. I
(City, town, or county) (State or foreign country)

10. Usual occupation house

11. Industry or business

12. Name Milton Living and

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

14. Maiden name Daisy Boyd

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

16. (a) Informant David F. Woodward,

(b) Address Walker, Missouri,

17. (a) removal (b) Date thereof 10-11-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nevada, Missouri

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 10-11-43 (b) D. C. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 108

(c) City or town Walker,
(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 X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 10
year 1943 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9/19 1943 to 10/10 1943
that I last saw him alive on 10/10 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Cholecystitis and papoth of wk,
Duration not stated

Due to pancreas

Due to pancreas

Other conditions: 469
(Include pregnancy within 3 months of death)

Major findings: none

Of operations: none

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? _____

While at work? no (Specify type of place)

(e) Means of injury _____

23. Signature [Signature] (M. D. or other)

Address 1103 grand Date signed 10/14/43

JAN 2 1944

JUN 29 1945

*Miss Woodward
Harris & McEwen*

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.