

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 71

Primary Registration District No. 3012

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

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Excelsior Springs Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hr (Specify whether
In this community 1 hr
years, months or days)

3. (a) PRINT FULL NAME: Lenda Lee Woods
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 single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 20 1948
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 1 hr. 0 min.

9. Birthplace Excelsior Springs, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Neeley F. Woods
13. Birthplace Wray, Colorado
(City, town, or county) (State or foreign country)
14. Maiden name Bonnie D. Porter
15. Birthplace Harrisonburg Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Neeley W. Woods
(b) Address R. # 1, Rayville, Mo.

17. (a) Burial (b) Date thereof 10/20/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eron Cemetery

18. (a) Signature of funeral director Clayton Richard

(b) Address Excelsior Springs, Mo.

19. (a) 10/21/48 (b) Christine Hutchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ray
(c) City or town 3 mi. north of Rayville
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 20
year 1948 hour 5 minute A. M.
21. I hereby certify that I attended the deceased from Oct. 20
1948 to Oct. 20 1948.
that I last saw her alive on Oct. 20 1948.
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurely developed. 7 Mo. child. Duration _____

Due to _____
Due to _____

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

Major findings: 15.9
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:
(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 Dr. M. J. ... (M. D. or other) M. D.
Address Excelsior Springs, MO Date signed 10/20/48

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-8-48

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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 Lindell K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.