

FILED FEB 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4615

State File No.

BIRTH NO. 49-007091 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 162

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>	
b. CITY (If inside corporate limits, write RURAL and give township) <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>	
c. LENGTH OF STAY (In this place) <u>0</u>		d. STREET ADDRESS (If rural, give location) <u>519- Washington</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>		e. DATE OF DEATH (Month) (Day) (Year) <u>2 18-49</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Gertrude</u>		b. (Middle) <u>Woods</u>	
c. (Last) <u>Woods</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 18-49</u>	
5. SEX <u>7 3</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>2-17-49</u>
9. AGE (In years last birthday) <u>2</u>	10. MONTHS <u>2</u>	11. IF UNDER 1 YEAR <u>2</u>	12. IF UNDER 4 HRS. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Springfield</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Thomas M Woods</u>		13b. MOTHER'S MAIDEN NAME <u>Willard Woods</u>	
14. NAME OF HUSBAND OR WIFE <u>Willard Woods</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Willard Woods</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Medical Certification</u>		19. ADDRESS <u>519- Washington</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tentorial Tear</u>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>2-21-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>760</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/17</u> , 19 <u>49</u> , to <u>2/18</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>48</u> , and that death occurred at <u>7:30 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Lynn W. Brown M.D.</u>		23b. ADDRESS <u>311 1/2 Boonville</u>	
23c. DATE SIGNED <u>2/19/49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>2-20-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hawlewood</u>	
24d. LOCATION (City, town, or county) (State) <u>Springfield Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Smith</u>	
25. ADDRESS <u>602 N. Jefferson</u>		DATE REC'D BY LOCAL REG. <u>2-19-49</u>	
REGISTRAR'S SIGNATURE <u>W. S. Handley</u>		25. ADDRESS <u>602 N. Jefferson</u>	

(Licensed/Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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.