

FILED AUG 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23156**
Registrar's No. **661**

128

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. **2000**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield	c. LENGTH OF STAY (in this place) 1 week	c. CITY (If outside corporate limits, write RURAL and give township) Siloam Springs	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns		d. STREET ADDRESS (If rural, give location) No street	

3. NAME OF DECEASED (Type or Print) a. (First) Lydia	b. (Middle) Brand	c. (Last) Woodruff	4. DATE OF DEATH (Month) (Day) (Year) July 24 1949
--	--------------------------	---------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH January 6, 1882	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-------------------------	----------------------------------	--	--	---	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Lamar, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	---

13a. FATHER'S NAME August Brand	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE -----
---	---	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dave Woodruff, Springfield, Missouri
---	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arterio-sclerosis Coronary Arteries.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4-201	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) na.	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 OF INJURY (Month) (Day) (Year) (Hour)	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 **July 17, 1949**, to **July 24, 1949**, that I last saw the deceased alive on **July 24, 1949**, and that death occurred at **5:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Sh. H. Maasup M.D. /	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 7/26/49
---	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE July 27, 1949	24c. NAME OF CEMETERY OR CREMATORY Hazelwood	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
--	-----------------------------------	--	---

DATE REC'D BY LOCAL REG. 7-27-49	REGISTRAR'S SIGNATURE W. H. Maasup M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alma Schmeyer F. H. Springfield, Mo
--	---	--

FEB 9 1950

OCT 8 1958

AUG 18 1954

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.

Signed _____
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Jewell E. Kiddle
2831
Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.