

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31026

State File No.
REG. DIST. NO. 200 - PRIMARY REG. DIST. NO. 5720 Registrar's No. 113

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

1. PLACE OF DEATH a. COUNTY MACON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MACON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MACON Rural Liberty		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MACON RURAL ROUTE	
d. FULL NAME OF HOSPITAL OR INSTITUTION ***** 1		d. STREET ADDRESS (If rural, give location) LIBERTY TWP.	
3. NAME OF DECEASED (Type or Print) a. (First) MONTRIE b. (Middle) T c. (Last) WOOD			4. DATE OF DEATH (Month) (Day) (Year) 9 28 49
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-4-78
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Macon County Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Robert Wood		13b. MOTHER'S MAIDEN NAME Margaret Cosby	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 Asville Wood ADDRESS Callao, Mo.
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) died about 5:30 P.M. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION: see autopsy	
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) Macon Missouri Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 Sudden , 19 49 , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J.B. Stohar, M.D. Surgeon		23b. ADDRESS Excello, Mo.	23c. DATE SIGNED 10-4-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-30-49	24c. NAME OF CEMETERY OR CREMATORY Steele	24d. LOCATION (City, town, or county) (State) Atlanta Missouri
DATE REC'D BY LOCAL REG. 10/8/49	REGISTRAR'S SIGNATURE Ruth McNeely	25. FUNERAL DIRECTOR'S SIGNATURE J.S. Edwards	ADDRESS Bevier, Mo.

Received 10/10/49
Marion Co. Health Dept
County File No. 10/49/19
DATE Filed 10/11/49

STATEMENT BY LICENSEE 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. 1961

P. O. Address _____ Bevier, Missouri _____

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.