

FILED FEB 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2014

State File No.

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 46

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>MISSOURI</u> b. COUNTY <u>PETTIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BOTHWELL MEMORIAL HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>624 - EAST 14th</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>PEARL</u>		b. (Middle) <u>G</u>	
c. (Last) <u>WOODSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 3, 1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 12, 1873</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>John W. Greer</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Head</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Geo. W. Woodson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. M. E. Green</u>		ADDRESS <u>624 E 14th Sedalia, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		5 years.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility- Chronic Myocarditis.</u>		25 years.	
DUE TO (c) <u>Bronchical Asthma.</u>		1 year.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bilateral Cataracts.</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>None. Medical treatment only/</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None.</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4222</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None.</u>		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>1.5 years</u> , 19 <u> </u> , to <u>Febr. 3rd, 1950</u> , that I last saw the deceased alive on <u>Febr. 3rd, 1950</u> and that death occurred at <u>I.P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Jno. B. Carlisle, M.D.</u>		23b. ADDRESS <u>5 Sedalia, Missouri.</u>	
23c. DATE SIGNED <u>2-4-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb 4, 1950</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-4-50</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Heekart</u>		ADDRESS <u>Sedalia, Mo</u>	

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

14-0804

RECEIVED

FEB 6

District Health Officer No. 8,

District File Number _____

Date Filed 2-10-50

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 Frank S. Coffman Jr

Licensed Embalmer No. 4559

P. O. Address Sedalia, 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.