

FILED MAR 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5802

5802

BIRTH NO. REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 55

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Monroe	
b. CITY OR TOWN Moberly		c. CITY OR TOWN Hallsidy, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION McDonough Hospital		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or Print) WILLIAM TAYLOR WOODS		4. DATE OF DEATH (Month) (Day) (Year) 2 24-1950	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 2/24 50
10a. USUAL OCCUPATION (The kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	9. AGE (In years last birthday) 61
11. BIRTHPLACE (State or foreign country) Monroe Co Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel Woods		13b. MOTHER'S MAIDEN NAME Rebecca McGee	
14. NAME OF HUSBAND OR WIFE Single		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OF NAME Nell Woods	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) chronic poisoning INTERVAL BETWEEN ONSET AND DEATH 2 days ANTECEDENT CAUSES DUE TO (b) Prostatic hypertrophy months DUE TO (c) blinx II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. Myocardial weakness year	
19a. DATE OF OPERATION 2-20-50	19b. MAJOR FINDINGS OF OPERATION Prostatic hypertrophy		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 OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 Jan 30 , 1950, to Feb 24 , 1950, that I last saw the deceased alive on 2-24 , 1950, and that death occurred at 8:53A m., from the causes and on the date stated above.			
23a. SIGNATURE W. H. McCormick D.O. (Degree or title)		23b. ADDRESS 300 1/2 Reed St. Moberly MO.	23c. DATE SIGNED 2-24-50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-26-50	24c. NAME OF CEMETERY OR CREMATORY Bethel	24d. LOCATION (City, town, or county) (State) Hallsidy Mo
DATE REC'D BY LOCAL REG. 2-26-50	REGISTRAR'S SIGNATURE Paul Williams	25. FUNERAL DIRECTOR'S SIGNATURE Fred G. Thompson	ADDRESS Madison Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED MAR 7
District Health Officer N
District File Number 3-22
Date Filed MAR 7 195

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.....

.....
working under my personal supervision.

..... Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Frank G. Thompson*
Licensed Embalmer No. *1420*

P. O. Address *Madison, Ma.*

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.