

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22425**

JUL 6 - 1953

BIRTH NO. _____ REG. DIST. NO. **274** PRIMARY REG. DIST. NO. **3052** Registrar's No. **215**

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Bates	
b. CITY OR TOWN Sedalia		c. CITY OR TOWN Butler	
d. FULL NAME OF HOSPITAL OR INSTITUTION Knox Nursing Home		d. STREET ADDRESS (If rural, give location) 402 East Ft. Scott	

3. NAME OF DECEASED (Type or Print)	a. (First) IDA	b. (Middle) Fi Dela	c. (Last) WOODS	4. DATE OF DEATH (Month) (Day) (Year) June 24, 1953
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 4, 1881	9. AGE (In years last birthday) 72	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) North Carolina	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Melvin Queen	13b. MOTHER'S MAIDEN NAME Bethany Mullies	14. NAME OF HUSBAND OR WIFE James A. Woods
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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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Helen Fullerton, Sedalia
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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 1946
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma (Primary Colon) with		
	DUPLICATE OF (b) Metastasis to liver.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 1950	19b. MAJOR FINDINGS OF OPERATION: Carcinoma of rectum sigmoid	20. AUTOPSY? 153X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. PLACE OF INJURY (Specify) (e.g., home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from _____, 19____, to **June 24, 1953**, that I last saw the deceased alive on **June 22, 1953**, and that death occurred at **1:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas J. Higgins, M.D.	23b. ADDRESS Sedalia, Mo	23c. DATE SIGNED 6/26/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Interment June 24, 1953	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY Butler, Mo	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 6-29-53	REGISTRAR'S SIGNATURE A. J. Campbell, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Reed Eckhart Sedalia, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

GILLESPIE FUNERAL HOME

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.