

FILED NOV 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33344

State File No.

BIRTH NO. _____ REG. DIST. NO. 73 PRIMARY REG. DIST. NO. 5291 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>LIBERTY-RURAL</u>	c. LENGTH OF STAY (In this place) <u>3 YRS</u>	c. CITY OR TOWN <u>LIBERTY</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>I.O.O.F. HOME</u>		No. STREET ADDRESS (If rural, give location) <u>I.O.O.F. HOME 6000</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>SARAH</u>	b. (Middle) <u>ALICE</u>	c. (Last) <u>JESSE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>NOV 7 1954</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB. 5, 1862</u>	9. AGE (In years last birthday) <u>92</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>W. W. WOODS</u>	13b. MOTHER'S MAIDEN NAME <u>NANCY STEPHENSON</u>	14. NAME OF HUSBAND OR WIFE <u>S. O. JESSE</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>JOHN JESSE, EX. SPRINGS, Mo.</u>	ADDRESS
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18. CAUSE OF DEATH Enter on one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Haemorrhage</u>	ANTECEDENT CAUSES		<u>10 days</u>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) <u>Arteriosclerosis.</u>		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS		
	Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 1950, to Nov 7, 1954, that I last saw the deceased alive on Nov 7, 1954, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm. J. Goodson MD</u>	23b. ADDRESS <u>Liberty, Mo</u>	23c. DATE SIGNED <u>11/11/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>11-7-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>	24d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Nov. 13, 1954</u>	REGISTRAR'S SIGNATURE <u>Mabel Strahan</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence Richard</u>	ADDRESS <u>Excelsior Springs, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *Lindell German*.....

Licensed Embalmer No. *4589*
Excelsior Springs,
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.