

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 21 1955

State File No. **32384**  
**545**

BIRTH NO. _____		REG. DIST. NO. <b>43</b>		PRIMARY REG. DIST. NO. <b>3007</b>		Registrar's No. _____				
1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b>				b. COUNTY <b>CARTER</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>POPLAR BLUFF</b>			c. LENGTH OF STAY (In this place) <b>1 DAY</b>		c. CITY OR TOWN <b>RURAL-JOHNSON TWP</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>POPLAR BLUFF HOSPITAL</b>				No. STREET ADDRESS (If rural, give location) <b>RT. 2 ELLISTORE, MISSOURI</b>				<b>0121</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>ESKER</b>			b. (Middle) <b>EDWARD</b>		c. (Last) <b>WOODARD</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT 27, 1955</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>12-11-1888</b>		9. AGE (In years last birthday) <b>66</b>		
						IF UNDER 1 YEAR Months <b>9</b>		IF UNDER 24 HRS. Days <b>16</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>CARTER COUNTY, MISSOURI</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>ANDY WOODARD</b>			13b. MOTHER'S MAIDEN NAME <b>MINNIE KELLY</b>			14. NAME OF HUSBAND OR WIFE <b>CARRIE EDITH WOODARD</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>CARRIE E. WOODARD, RT. 2, ELLISTORE, MO.</b>					
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) <b>Cerebral Vascular Accident</b>					INTERVAL BETWEEN ONSET AND DEATH	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>331X</b>						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						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 <b>9-26</b> , 19 <b>55</b> , to <b>9-27</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9-27</b> , 19 <b>55</b> , and that death occurred at <b>11:20pm.</b> , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <b>W. L. ...</b>				23b. ADDRESS <b>Poplar Bluff Mo.</b>			23c. DATE SIGNED <b>10-8-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>OCT 2 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ADDICCH VALLEY CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>CARTER COUNTY, MISSOURI</b>				
DATE REC'D BY LOCAL REG. <b>10/12/55</b>		REGISTRARS SIGNATURE <b>[Signature]</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>COLEMAN MCSPADDEN</b>		ADDRESS <b>VAN BUREN, MISSOURI</b>			

RECEIVED  
OCT 17 1955  
BUTLER CO. HEALTH CENTER  
FILE No. \_\_\_\_\_

1955  
OCT 17 8 47 AM

OCT 26 1955

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 Allen C. McPherson

Licensed Embalmer No. 454

P. O. Address Van Buren

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.