

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **37477**

FILED DEC 6 1955

BIRTH NO. _____		REG. DIST. NO. <u>207</u>		PRIMARY REG. DIST. NO. <u>5758</u>		Registrar's No. <u>49</u>	
1. PLACE OF DEATH a. COUNTY <u>Maries</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Maries</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Miller</u>		c. LENGTH OF STAY (in this place) <u>_____</u>		c. CITY OR TOWN <u>Rural Miller</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>_____</u>				f. STREET ADDRESS (If rural, give location) <u>0630</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u>		b. (Middle) <u>_____</u>		c. (Last) <u>Wodohodsky</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>7/11/1882</u>	
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Wenzel Wodohodsky</u>		13b. MOTHER'S MAIDEN NAME <u>Maria Schirr</u>		14. NAME OF HUSBAND OR WIFE <u>Rosa Wodohodsky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Rosa Doyel, Brinktown, Missouri</u> ADDRESS <u>_____</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute congestive heart failure</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic congestive heart failure</u> DUE TO (c) <u>Chronic myocarditis, Mitral insufficiency</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>410X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>  <u>3 years</u>  <u>unknown</u>	
19a. DATE OF OPERATION <u>_____</u>		19b. MAJOR FINDINGS OF OPERATION <u>_____</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>_____</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>_____</u>		21f. HOW DID INJURY OCCUR? <u>_____</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u>_____</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>October 2</u> , 19 <u>52</u> , to <u>Nov 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>55</u> , and that death occurred at <u>8:30A. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Rouley Gates</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>Dixon, Mo.</u>		23c. DATE SIGNED <u>11-28-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/28/1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Brinktown Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Maries County, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>11-29-55</u>		REGISTRAR'S SIGNATURE <u>Pauline Howard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred H. Gilbert, Dixon, Missouri</u> ADDRESS <u>_____</u>			

(Licensed Embalmer's Statement on Reverse Side)

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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 *Maurice E. Schissel*

Licensed Embalmer No. *450*

P. O. Address *Dixon, Missouri*

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.