

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26138

State File No. ....

FILED AUG 27 1956

888

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. ....

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>SAVANNAH</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3 DAYS</u>		f. STREET ADDRESS (If rural, give location) <u>R.F.D. 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>EATL</u> b. (Middle) <u>Claget</u> c. (Last) <u>WOOD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>aug 17-1956</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>NOV 1-1881</u>		9. AGE (In years last birthday) <u>74</u>		10. UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 1 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <u>DAVISS CO. MO.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>Joseph Leonard Wood</u>		13b. MOTHER'S MAIDEN NAME <u>Clara M. Edwards</u>		14. NAME OF HUSBAND OR WIFE <u>Iva M. Wood</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Wm. Lee Wood RFD 1 Savannah Mo</u>	
(If yes, give war or dates of service)		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		ADDRESS	

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</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.			
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"/>			

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) m.		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 8-14 1956 to 8-16, 1956 that I last saw the deceased alive on 8-15, 1956 and that death occurred at St. Joseph from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. D. F. Jones M.D.</u>		23b. ADDRESS <u>St. Joseph Mo</u>		23c. DATE SIGNED <u>8-16-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-17-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Winston</u>	
24d. LOCATION (City, town, or county) (State) <u>Winston MO</u>		24e. DATE REC'D BY LOCAL REG. <u>Aug 17, 1956</u>		24f. REGISTRAR'S SIGNATURE <u>Lothar W. Allison</u>	

25. FUNERAL DIRECTOR'S SIGNATURE <u>Breit Funeral Home Savannah Mo</u>		ADDRESS <u>Savannah Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4850

MAR 30 1958

MS  
APR 15 1959

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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..... *E. C. Breit* .....

Licensed Embalmer No. *2650*

P. O. Address *Savannah* .....

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.