

Health,
Welfare
Public
Service

FILED OCT 15 1956

STANDARD CERTIFICATE OF DEATH

30462

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 919

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD <u>2394</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CONNELLY home		Length of stay in 1b 35 years	d. STREET ADDRESS (If outside, give location) 1330 CHERRY STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) VESTA WOOD			4. DATE OF DEATH Oct. 8 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1872	9. AGE (In years last birthday) 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (City and state or country) Sweetspring, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Wood		14. MOTHER'S MAIDEN NAME Rosina Pollard		
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. None	17. INFORMANT Mrs. Rosina Waller, Kansas City Mo Address 2820 E. 7th.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENCEPHALO MALACIA			INTERVAL BETWEEN ONSET AND DEATH 4 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) HYPERTENSIVE CARDIO VASCULAR DISEASE		years
	DUE TO (c) acufe enteritis		24 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 443x			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour 11:40 Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 1952 to Oct. 8, 1956 and last saw her alive on Sept. 23, 56 Death occurred at 11:40 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE GUY D. CALLOWAY JR. M.D.		22b. ADDRESS SPRINGFIELD, MISSOURI	22c. DATE SIGNED Oct 12, 56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 10, 56	23c. NAME OF CEMETERY OR CREMATORY Park Cemetery	23d. LOCATION (City, town, or county) (State) Carthage Missouri
24. FUNERAL DIRECTOR Ayre-Goodwin, Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 10-12-56	26. REGISTRAR'S SIGNATURE Walter Williamson

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

4

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....*Murray Wilson*.....
Licensed Embalmer No. *498*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.