

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32835**

FILED OCT 15 1956

BIRTH NO. _____ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **6093** Registrar's No. **156**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE No. _____ b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Marshall	c. LENGTH OF STAY (in this place) 27 yrs	c. CITY OR TOWN Marshall	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 County Home		e. STREET ADDRESS (If rural, give location) R F D 0910	

3. NAME OF DECEASED (Type or Print)	a. (First) Franklin	b. (Middle) Carl	c. (Last) Wood	4. DATE OF DEATH (Month) (Day) (Year) Oct. 6-1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Apr. 21-1897	9. AGE (In years last birthday) 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inmate		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Pearl, Ill.	12. CITIZEN OF WHAT COUNTRY? U S

13a. FATHER'S NAME A. C. Wood	13b. MOTHER'S MAIDEN NAME Belle Garrison	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Beth Sprtsman, Kansas City, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 30 min.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES DUE TO (b) Hypertension <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

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) 331x
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 **Dec - 1955**, to **Dec 5 - 1956**, that I last saw the deceased alive on **Oct 3, 1956**, and that death occurred at **8:40 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE C. L. Lawless, M.D. (Degree or title)	23b. ADDRESS Marshall Mo.	23c. DATE SIGNED 10-6-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-7-1956	24c. NAME OF CEMETERY OR CREMATORY City Cemetery
		24d. LOCATION (City, town, or county) (State) Slater, Mo.

DATE REC'D BY LOCAL REG. 10-7-56	REGISTRAR'S SIGNATURE Carl G. Reed	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Hill Brothers Slater, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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..... *A. C. Hill*

Licensed Embalmer No. *309*

P. O. Address *State*

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.