Health, Welfare Public Service

300
1-56

FILED APR 8 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 9557

Registration District No. 254 Primary Registration District No. 4386 Registrar's No. 22

1. PLACE OF DEATH
a. COUNTY Oregon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Thayer — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b: 70 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Oregon
c. CITY OR TOWN Thayer 07500 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Margaret Middle Elizabeth Last Woodward

4. DATE OF DEATH Month March Day 25 Year 1957

5. SEX Female 1

6. COLOR OR RACE White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH June 15, 1873

9. AGE (In years last birthday) 83

IF UNDER 1 YEAR: Months 9 Days 10 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Domestic

11. BIRTHPLACE (City and state or country) Lawrence Co., Arkansas 1

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Wesley Williams

14. MOTHER'S MAIDEN NAME Betsy Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT Olive Martin, Thayer, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mitral Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary thrombosis
DUE TO (c) Senility

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 410X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 March 14, 1957 to March 25, 1957 and last saw her/him alive on
Death occurred at 4 A M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Dee Cooper (Degree or title) M D

22b. ADDRESS Thayer Mo

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 3-27, 1957

23c. NAME OF CEMETERY OR CREMATORY Thayer Cemetery

23d. LOCATION (City, town, or county) (State) Thayer, Missouri

24. FUNERAL DIRECTOR Orland Carter — ADDRESS Thayer Mo

25. DATE RECD. BY LOCAL REG. 3-30-57

26. REGISTRAR'S SIGNATURE Arthur Wolff

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

468

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 456

P. O. Address .....

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