

Health,
& Welfare
S. Public
Health Service

S. 300
v. 1-56

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.

Some information for contribution in the specific manner required by 193.140 MoRS 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45409
STATE FILE NUMBER

FILED DEC 23 1957

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 300

1. PLACE OF DEATH a. COUNTY <i>Randolph</i>		2. USUAL RESIDENCE (Where deceased lived. If institution) Residency before admission a. STATE <i>Missouri</i> b. COUNTY <i>Randolph</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Moberly</i> OR TOWN Inside Limits? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Moberly</i> Inside Limits? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 88-2	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Woodland Hospital 2 Hours</i>		d. STREET ADDRESS (If outside, give location) <i>951 W. Collins</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>SADIE BELLE WOOD</i>		4. DATE OF DEATH Month Day Year <i>Dec-11-1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July-27-1889</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Patterson Dept. Store</i>	11. BIRTHPLACE (City and state or country) <i>Mason County Mo.</i>
13. FATHER'S NAME <i>James Cox</i>		14. MOTHER'S MAIDEN NAME <i>Mary Agnes Raybuck</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>496-26-9299</i> INFORMANT <i>Mrs. Ray Cred Moberly Mo</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>
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 Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>12/11/57</i> to <i>12/11/57</i> and last saw her/him alive on <i>12/11/57</i> . Death occurred at <i>3:00 P. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Robert Mason, M.D.</i>		22b. ADDRESS <i>121 S. Wms Moberly Mo</i>	22c. DATE SIGNED <i>12/11/57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Dec-13-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sunset Memorial Under</i>	23d. LOCATION (City, town, or county) (State) <i>Moberly Missouri</i>
24. FUNERAL DIRECTOR <i>Cater Funeral Home Moberly Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>12/13/57</i>	26. REGISTRAR'S SIGNATURE <i>E. DeWolfe</i>

(Licensed Embalmer's Statement on Reverse Side)

69

JAN 9 1958

MAY 14 1958

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 *George R. Carter*

Licensed Embalmer No. *4906*

P. O. Address *Meriden, Conn.*

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.