

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001903

STATE FILE NUMBER

FILED FEB 9 1959

Registration District No. 169 Primary Registration District No. _____ Registrar's No. 7

300
1-57

1. PLACE OF DEATH a. COUNTY Knox		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) Knox City, Bee Ridge Twp		c. CITY OR TOWN Yarrow	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL Orat daughters home		d. STREET ADDRESS (If outside, give location) Benton Twp	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Oscar Wood			4. DATE OF DEATH Month Day Year Jan. 31, 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 8, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Adair county, Mo
13a. FATHER'S NAME George W. Wood		13b. MOTHER'S MAIDEN NAME Rosetta Lagle	14. NAME OF HUSBAND OR WIFE Edith Sallee
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown <input type="checkbox"/> If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 186-12-7450	17. INFORMANT Address Mrs. Edith Wood, Knox City, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Decompensated Coe Pulmonary with Circulatory Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Pulmonary Emphysema DUE TO (c) Chronic Bronchial Pathosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 Jan. 25, 1959 to Jan. 27, 1959 and last saw her alive on Jan. 27, 1959 Death occurred at 605 Ph on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. H. Gibson, D.D.		22b. ADDRESS Adair, Mo.	22c. DATE SIGNED 1-31-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/2/59	23c. NAME OF CEMETERY OR CREMATORY Yarrow Cemetery	23d. LOCATION (City, town, or county) (State) Adair county, Mo.
24. FUNERAL DIRECTOR Paul M. Riley		ADDRESS Kirkville, Mo.	25. DATE RECD. BY LOCAL REG. 2-4-59
		26. REGISTRAR'S SIGNATURE Nelle S. Nussall	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 W. Davalt*

Licensed Embalmer No. *4799*

P. O. Address *Hicksville Mo*

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.