

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004515  
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 103

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Fulton</b> <b>0140</b> c.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>University Med. Cen.</b>		Length of stay in lb <b>4 Hrs</b>	d. STREET ADDRESS (If outside, give location) <b>R.F.D.# 2</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Robin</b> Middle <b>Lynn</b> Last <b>Woods</b>			4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan, 4, 1959</b>	9. AGE (In years last birthday) <b>1</b> Months <b>25</b> Hours <b>05</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Fulton, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Francis A. Woods</b>	13b. MOTHER'S MAIDEN NAME <b>Valeria E. Klott</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Hospital Chart, University, Columbia</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute sub-dural hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION <b>Fulton</b>	COUNTY <b>Callaway</b>	STATE <b>Mo</b>
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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 <b>Fulton</b>	COUNTY <b>Callaway</b>	STATE <b>Mo</b>
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21. I attended the deceased from <b>6:17</b> <b>Coroner's Case</b> and last saw her alive on _____ Death occurred at _____ <b>P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Vincent P Perue, M.D.</b>	22b. ADDRESS <b>University of Missouri</b>	22c. DATE SIGNED <b>2 Mar. 1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar, 3, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Callaway Memorial Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Fulton Mo</b>
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24. FUNERAL DIRECTOR <b>Wallace Funeral Home, Fulton Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Mar. 3, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>
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(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 *Denzil C. Browning* .....

Licensed Embalmer No. *2724* .....

P. O. Address *Fairfax, 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.