

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021791

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2884

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY JACKSON |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Mo.         |  | c. CITY OR TOWN Kansas City, Mo.   |  |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>          |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp |  | d. STREET ADDRESS (If outside, give location) 4016 Warwick   |  |
| Length of stay in 1b 28 YEARS  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |

|   |                        |  |   |                                    |  |
|---|------------------------|--|---|------------------------------------|--|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last Maude E Wood                                 |                        |  | 4. DATE OF DEATH<br>Month Day Year JUNE 12 1959               |                                    |  |
| 5. SEX Female   | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 17, 1874                                | 9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months Days 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  | 11. BIRTHPLACE (City and state or country) FORT SCOTT, KANSAS | 12. CITIZEN OF WHAT COUNTRY? U S A |  |

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME ALLISON GARDNER  | 13b. MOTHER'S MAIDEN NAME ARIETTA CUMMINGS | 14. NAME OF HUSBAND OR WIFE MILTON STANLEY WOOD       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE | 16. SOCIAL SECURITY NO. NONE               | 17. INFORMANT Address ARTHUR L. WOOD, BUTLER MISSOURI |

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|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction |  | INTERVAL BETWEEN ONSET AND DEATH 48 hours. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Thrombosis                             |  | 48 hours.                                  |
| DUE TO (c) Coronary Sclerosis   |  | 10 years.                                  |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Atherosclerosis, generalized; Hydrothorax, 6 lateral. 4201 |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <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 1949 to 6/12/59 and last saw her alive on 6/12/59  
Death occurred at 8:10 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.

|  |   |                          |
|--|---|--------------------------|
| 22a. SIGNATURE P. L. Byers M.D. (Degree title) | 22b. ADDRESS 4635 Wyanette St. K.C. 12, Mo. | 22c. DATE SIGNED 6/13/59 |
|--|---|--------------------------|

|   |                   |   |   |
|---|-------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 6-14-59 | 23c. NAME OF CEMETERY OR CREMATORY WICHITA PARK | 23d. LOCATION (City, town, or county) (State) WICHITA, KANSAS |
|---|-------------------|---|---|

|   |                                      |   |
|---|--------------------------------------|---|
| 24. FUNERAL DIRECTOR STINE & MC CLURE UND. CO. K C, MO. | 25. DATE RECD. BY LOCAL REG. 6-13-59 | 26. REGISTRAR'S SIGNATURE Neva Minshall |
|---|--------------------------------------|---|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

P. L. Byers

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 *William M. Jura* .....

Licensed Embalmer No. *464* .....  
P. O. Address *Kansas City, 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.