

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 27 1959

59-024876

STATE FILE NUMBER

Registration District No. 33 Primary Registration District No. 3022 Registrar's No. 85

1. PLACE OF DEATH a. COUNTY <u>Harrison</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u> Length of stay in 1b <u>2 week</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Noll Memorial</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u> c. CITY OR TOWN <u>Rural Fox Creek</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>12 mile East Bethany</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Oscar Wooderson</u>			4. DATE OF DEATH Month Day Year <u>July 19, 1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (City and state or country) <u>Harrison County, Mo., U. S.</u>			
13a. FATHER'S NAME <u>James Wooderson</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Osa Wooderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Osa Wooderson, Mt. Moriah, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RT. CEREBRAL HEMORRHAGE.</u> DUE TO (b) <u>ARTERIO SCLEROTIC CEREBRAL VASCULAR DISEASE - years</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 a.m. p.m. Month, Day, Year		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 <u>7-5-59</u> to <u>7-19-59</u> and last saw ^{her} him alive on <u>7-19-59</u> Death occurred at <u>7:50</u> <u>P</u> .m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Allen A. Dubbe M.D.</u>			22b. ADDRESS <u>Bethany, Mo.</u>		22c. DATE SIGNED <u>7-22-59</u>		
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>	23b. DATE <u>7-22-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon</u>		23d. LOCATION (City, town, or county) <u>Mt. Moriah, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>M. B. Haas, Bethany, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-22-1959</u>	26. REGISTRAR'S SIGNATURE <u>Gella Mayey</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 3899

P. O. Address Bethany

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.