

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038573**

FILED 1959 OCT 26

STATE FILE NUMBER

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 11

MAILED

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Slater</b>		Length of stay in 1b <b>40 Yrs</b>	c. CITY OR TOWN <b>Slater</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>109 E. Lincoln</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>109 E. Lincoln</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>(None)</b> Last <b>Woods</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>19</b> Year <b>1959</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-1869</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>New Franklin, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Gordon Mc Gavock</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Lewis</b>	14. NAME OF HUSBAND OR WIFE <b>J. Roger Woods</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 Address <b>J. Roger Woods, Slater, Mo.</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>Cerebral Hemorrhage.</b> DUE TO (b) <b>Hypertensive Cardiovascular Disease.</b> DUE TO (c) <b>Arteriosclerosis.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 weeks</b>
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.)
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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
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21. I attended the deceased from <b>March-1952</b> to <b>Oct-18-59</b> and last saw her alive on <b>Oct-19-59</b> . Death occurred at <b>8-p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>J. Nelson Sanchez M.D.</b> (Degree or title)	22b. ADDRESS <b>313 1/2 N. Main Slater</b>	22c. DATE SIGNED <b>10-20-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 22 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Ridge</b>	23d. LOCATION (City, town, or county) <b>Fayette Mo</b>
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24. FUNERAL DIRECTOR <b>Haines Funeral Home Slater, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-22-59</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Raymond Brame</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 8 1960

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 Guy F. Hays, Jr.

Licensed Embalmer No. 4630

P. O. Address Slater, Md.

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.