

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS JAN 14 1960

-60-000642

Registration District No. 54 Primary Registration District No. 4097 Registrar's No. 7 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CASS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CASS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HARRISONVILLE</u>		Length of stay in 1b <u>17Yrs.</u>	c. CITY OR TOWN <u>HARRISONVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>906 S. INDEPENDENCE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>906 S. INDEPENDENCE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE NAOMI WOODMAN</u>			4. DATE OF DEATH Month Day Year <u>JAN 1 1960</u>		
---	--	--	---	--	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1871</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	---------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME-MAKER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>GARDEN CITY, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>PHINEBUS MOORE WILLS</u>	13b. MOTHER'S MAIDEN NAME <u>SELINDA ESBEY</u>	14. NAME OF HUSBAND OR WIFE <u>FRANK W WOODMAN</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>Mrs James Taylor</u>	Address <u>HARRISONVILLE, 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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arteriosclerosis</u>	
	DUE TO (c) <u>---</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 checked="" 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.) <u>---</u>
---	---	--

20c. TIME OF INJURY Hour a.m. p.m. <u>---</u>	Month, Day, Year <u>---</u>
---	--------------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY <u>---</u>	STATE <u>---</u>
---	--	--	----------------------	---------------------

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on JAN 1, 1960  
 Death occurred at 7:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>MD</u>	22b. ADDRESS <u>Harrisonville Mo.</u>	22c. DATE SIGNED <u>JAN 2, 1960</u>
--------------------------------------	--------------------------------	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-3-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARDEN CITY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>GARDEN CITY, MISSOURI</u>
--	------------------------------	---	---

24. FUNERAL DIRECTOR <u>ATKINSON Dickey</u>	ADDRESS <u>HARRISONVILLE, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>1-3-1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Taylor Esbey</u>
--	--------------------------------------	---	---

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

NS  
MAR 8  
1901

**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 Robert W. Wilkinson

Licensed Embalmer No. 4902

P. O. Address Waukegan, Ill.

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.