

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004910

FILED VS. FEB 10 1960 374

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <b>Worth</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Grant City</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Grant City</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>Grant City Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Wood</b> Last <b>Wood</b>	4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1960</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>11-1-1884</b>	9. AGE (last birthday) <b>75</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>Ret. Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Bedford, Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>
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13a. FATHER'S NAME <b>Maynard Winslow Wood</b>	13b. MOTHER'S MAIDEN NAME <b>Susanna Anders</b>	14. NAME OF HUSBAND OR WIFE <b>Never Married</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>Mary E. Tippie - Parnell, Missouri</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>Arteriosclerotic Cardiovascular Disease</b> <b>And Diabetes Mellitus and gangrenous rtfoot (lyr)</b> DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15years</b>
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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)	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
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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 _____ a.m. _____ p.m. Month, Day, Year _____
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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 <b>Grant City</b>	COUNTY <b>Mo</b>	STATE <b>Mo</b>
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21. I attended the deceased from **1947** to **Jan 27, 60** and last saw her alive on **Jan 26, 60**  
Death occurred at **2:45pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Frank B Matteson MD</b>	22b. ADDRESS <b>Grant City Mo</b>	22c. DATE SIGNED <b>1/30/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>1-29-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Isadora Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Isadora, Missouri</b>
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24. FUNERAL DIRECTOR <b>Bill Dwyer - Grant City</b>	25. DATE RECD. BY LOCAL REG. <b>Feb 5 1960</b>	26. REGISTRAR'S SIGNATURE <b>Dawdy Kobe</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

12/10/68

**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 Bill A. Dunfee

: Licensed Embalmer No. 4902

P. O. Address Grant

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.