

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007225

FILED VS FEB 18 1960

200 Primary Registration District No. 3041 Registrar's No. 27

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>MACON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>MACON</u>			Length of stay in 1b <u>5 HRS</u>		c. CITY OR TOWN <u>WOODLAWN</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>SAMARITAN HOSP</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>WOODLAWN MO</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FREDRICK</u> Middle <u>WOODS</u> Last <u>WOODS</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>10</u> Year <u>1960</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>SEPT 15 1878</u>	
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>MO MONROE COUNTY</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>			
13a. FATHER'S NAME <u>JAMES FREDRICK WOODS</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH ANN GLASSCOCK</u>			14. NAME OF HUSBAND OR WIFE <u>CLARENCE WOODS</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 MARION WOOD CLARENCE MO</u> Address _____			
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>TERMINAL LOBAR PNEUMONIA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARDIO-RENAL-VASCULAR DISEASE</u>							<u>MONTHS</u>
DUE TO (c) <u>HYPERTENSION</u>							<u>YEARS</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 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.		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>6-6-1953</u> to <u>2-6-1960</u> and last saw him alive on <u>2-7-1960</u> Death occurred at <u>12:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Alvan R. Hull D.O.</u>				22b. ADDRESS <u>Clarence, Mo.</u>		22c. DATE SIGNED <u>2-11-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2-8-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE WOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>	
24. FUNERAL DIRECTOR ADDRESS <u>GREENING CLARENCE MO</u>				25. DATE RECD. BY LOCAL REG. <u>2/13/60</u>		26. REGISTRAR'S SIGNATURE <u>Walter M. Sweeney</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 23 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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles V. Green

Licensed Embalmer No. 4620

P. O. Address Clasencia

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