

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048869  
STATE FILE NUMBER

FILED VS JAN 17 1961

Registration District No. 187 Primary Registration District No. 5693 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Livingston</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Dawn</b>	Length of stay in 1b	c. CITY OR TOWN <b>Dawn,</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	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>PEARL</b> Middle Last <b>WOODEN</b>			4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>1960</b>			
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>3-5-88</b>	9. AGE (last birthday) <b>72</b>	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) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Carroll County, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>		

13a. FATHER'S NAME <b>James M. Wooden</b>	13b. MOTHER'S MAIDEN NAME <b>Rannie Stagner</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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>Mrs. Leslie Rowland: 3664 Harrison Kansas City Mo</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>Few Minutes</b>
IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		

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	
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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.)	
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

21. I attended the deceased from **None** to **None** and last saw her alive on **Dec. 24-60**  
Death occurred at **8:00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Joseph A. Conrad, M.D. Coronet</b>	22b. ADDRESS <b>Chillicothe, Mo</b>	22c. DATE SIGNED <b>Dec. 29-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-27-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Eron</b>
23d. LOCATION (City, town, or county) <b>Carroll County, Mo.</b>		(State)

24. FUNERAL DIRECTOR <b>Norman Funeral Home; Chillicothe, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Jan 9, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Annalee Taylor</b>
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Mo. (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 2 1967

**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

*John P. Rodgers*

Licensed Embalmer No. 4963

P. O. Address Chillicothe

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.