

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004259

FILED VS JAN 23 1967

Registration District No. 224 Primary Registration District No. 30720 Registrar's No. 13

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY SALINE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY SALINE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHALL		c. CITY OR TOWN MARSHALL	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 510 E. MORROW		d. STREET ADDRESS (If outside, give location) 510 E. MORROW	
3. NAME OF DECEASED (Type or print) First DEBRA Middle GAIL Last WOOD		4. DATE OF DEATH Month 1 Day 16 Year 61	
5. SEX F	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/10/60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 0
11. BIRTHPLACE (City and state or country) MARSHALL, MO.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME JAMES C. WOOD		13b. MOTHER'S MAIDEN NAME GEORGIA MAE ROBINSON	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT JAMES C. WOOD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia		INTERVAL BETWEEN ONSET AND DEATH 1 day	
DUE TO (b) Abscess, atelectasis,			
DUE TO (c) Emphysema left lung (3 weeks premature)		3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Sensitivity		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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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 1/15/61 to 1/16/61 and last saw ^{her} _{him} alive on 1/15/61 Death occurred at _____ a _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Marvin E. Roehrs M.D. (Degree or title)		22b. ADDRESS Marshall Mo	22c. DATE SIGNED 1/18/61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/18/61	23c. NAME OF CEMETERY OR CREMATORY FAIR VIEW CEMETERY	23d. LOCATION (City, town, or county) (State) MARSHALL, MO.
24. FUNERAL DIRECTOR George H. Green	ADDRESS 516 E Jackson Marshall, Mo	25. DATE RECD. BY LOCAL REG. 1-18-61	26. REGISTRAR'S SIGNATURE Cecil G. Reed

004400.3013

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 *George H. Green*
Licensed Embalmer No. 4220

P. O. Address *Indian, Mo.*

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.