

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5512-61-041347
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

AMENDED

FILED NOV 17 1961

1. PLACE OF DEATH
a. COUNTY **JACKSON**
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **KANSAS CITY** Length of stay in 1b **22 yrs.**
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **1010 Bellefontaine** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MISSOURI** b. COUNTY **JACKSON**
c. CITY OR TOWN **KANSAS CITY** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **1010 Bellefontaine** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last **CLARENCE EDWARD WOOD** 4. DATE OF DEATH Month Day Year **11-2-1961**

5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **3-22-1888** 9. AGE (last birthday) **73** IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min. **- - - -**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **BRICKLAYER** 10b. KIND OF BUSINESS OR INDUSTRY **Unknown** 11. BIRTHPLACE (City and state or country) **Springfield, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **BRYANT WOOD** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Pearl WOOD**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **NO** 17. INFORMANT Address **Pearl WOOD 1010 Bellefontaine**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **TRANSITION**
DUE TO (b) **CARCINOMA OF STOMACH**
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION COUNTY STATE **KANSAS CITY JACKSON MO.**

21. I attended the deceased from **8-1-61** to **11-2-61** and last saw him/her alive on **10/9/61**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Joseph M. Masucci M.D.** 22b. ADDRESS **Kansas City, Mo** 22c. DATE SIGNED **11/3/61**

23a. BURIAL, CREATION, REMOVAL (Specify) **Burial** 23b. DATE **11-4-1961** 23c. NAME OF CEMETERY OR CREMATORY **Mt. Washington** 23d. LOCATION (City, town, or county) (State) **Kansas City, Mo**

24. FUNERAL DIRECTOR ADDRESS **C.H. Blackman & Son Inc. K.C., Mo.** 25. DATE RECD. BY LOCAL REG. **11-3-61** 26. REGISTRAR'S SIGNATURE **Ruth Long**

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address R.C., Ma

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.