

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045417

STATE FILE NUMBER

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 97

FILED DEC 21 1961

| | | | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u> | | Length of stay in 1b <u>7 Das.</u> | | c. CITY OR TOWN <u>Odessa</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>Lexington Memorial Hospt.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>WEST WALNUT</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Woods</u> Last <u>Woods</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1961</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-22-74</u> | | 9. AGE (last birthday) <u>86</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | | 11. BIRTHPLACE (City and state or country) <u>Lafayette Co., Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>Joseph Woods</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Nannie Nelson</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>None</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 Address <u>Mrs. Clark Fegert, Raytown, Mo.</u> | | | | | | | |
| 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>Diabetic Acidosis</u> DUE TO (b) <u>Diabetic Gangrene Left Foot</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 days</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 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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u> | | 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>Dec. 2, 1961</u> to <u>Dec. 11, 1961</u> and last saw her/him alive on <u>Dec. 11, 1961</u> Death occurred at <u>6:00 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Joe W Ward MD</u> (Degree or title) | | | | | | 22b. ADDRESS <u>Lexington, Mo</u> | | | 22c. DATE SIGNED <u>12, 12, 61</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Dec. 14, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u> | | | 23d. LOCATION (City, town, or county) <u>Odessa, Mo.</u> (State) | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Husman-Sparks, Odessa, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>12-14-61</u> | | 26. REGISTRAR'S SIGNATURE <u>Maureen E Eastbrook</u> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Henry L. Heron*

Licensed Embalmer No. 7541

P. O. Address *Clermont*

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.