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7-39  
X23159

**APR 23 1940**  
Registration District No. **417**

Primary Registration District No. **3021**

Registrar's No. **108**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH**

(a) County Jasper

(b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: JANE QUINN HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community CEYLON  
years, months or days

**3. (a) PRINT FULL NAME** Josephine W. Woodard

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Josephine Woodard 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Oct 10 1859  
(Month) (Day) (Year)

<b>8. AGE:</b>	Years	Months	Days	If less than one day
	<u>80</u>	<u>11</u>	<u>26</u>	hr. _____ min. _____

9. Birthplace Beaver Dam Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business R. R. Man

**MOTHER FATHER**

12. Name M. Woodard

13. Birthplace New York  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Josephine Woodard

(b) Address 83 N. Campbell

17. (a) Removal (b) Date thereof Oct 7 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Valley, Kansas

18. (a) Signature of funeral director Webb City Ind Co.

(b) Address Webb City Mo

19. (a) OCT. 7. 40 (b) J. L. ...  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jasper

(c) City or town Webb City  
(If outside city or town limits, write "RURAL")

(d) Street No. 83 N. Campbell  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 6  
year 1940 hour 12 minute 30 P M.

21. I hereby certify that I attended the deceased from Oct 3 1940  
Oct 6 1940 to Oct 6 1940;  
that I last saw him alive on Oct 6 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic fibroid myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

Signature R. M. Stormont (M. D. or other) \_\_\_\_\_  
Address Webb City Mo Date signed 10/7/40

See affidavit no 277 in misc file #1940

**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 myself

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Chyten M. Johnston

Licensed Embalmer No. 3,922

P. O. Address Webb City, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**