

X36871

FILED FEB 24 1944
Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 129

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 805 Main St. (Home)
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 hrs. 14 min.
5 hrs. 15 min. (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 805 Main St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Dorothy Evaline Woosley
 (b) If veteran, name war None
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 4
 year 1944 hour 4 minute 45 P.M.

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Single
 (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from 9:30 AM 2-4, 1944, to 4:45 PM 2-4, 1944
 that I last saw her alive on Feb-4, 1944
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: February 4, 1944
(Month) (Day) (Year)
 8. AGE: Years 0 Months 0 Days 0 If less than one day 5 hrs, 15 min
hr. min.

Immediate cause of death: Torangan Ovale failed to close
 Due to _____
 Due to _____

9. Birthplace: St. Joseph, Missouri
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) 1572

10. Usual occupation None

Major findings: _____
 - Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name William Woosley
 13. Birthplace Grand Island Nebraska
(City, town, or county) (State or foreign country)
 14. Maiden name Letha Barnes
 15. Birthplace Iowa
(City, town, or county) (State or foreign country)

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

16. (a) Informant William Woosley (father)
 (b) Address 805 Main St. (City)
 17. (a) Burial (b) Date thereof 2/6/44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation I.O.O.F. Cemetery

22. If death was due to external causes, fill in the following:
 (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? _____

18. (a) Signature of funeral director John E. Krupp
 (b) Address 6054 Pryor Ave., City
 19. (a) 2-6-44 (b) Are Henry
(Date received local registrar) (Registrar's signature)

While at work? _____
(Specify type of place) (c) Means of injury
 23. Signature J R Elliott (M. D. or other) md
 Address 801 1/2 Francis St. Springfield Mo. Date signed 2-5-44

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

MOTHER FATHER

1233

501 1/2 Francis.
Dr. Elliott.

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

....., Registered Apprentice No.
.....
working under my personal supervision.

Signed *John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, 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 this body is not embalmed, fact should be so stated above.