

**FILED OCT 17 1946**

Registration District No. **210**

Primary Registration District No. **3054**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Pike**  
(b) City or town **Louisiana Mo**  
(c) Name of hospital or institution: **Pike Co. Hospital**  
(d) Length of stay: **8 days**  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pike** **82**  
(c) City or town **Rural** **0**  
(d) Street No. **Eolia Mo** **0**  
(e) Citizen of foreign country? **no** (Yes or No) **0**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Martha Jane Woods**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **F** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**  
6. (b) Name of husband or wife **deceased** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: **Oct 23 1959**  
(Month) (Day) (Year)

8- AGE: Years **86** Months **10** Days **12** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Pike Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **house wife**

11. Industry or business \_\_\_\_\_

12. Name **John Akers**

13. Birthplace **va**  
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **unknown** **9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Emil Akers**

(b) Address **Eolia Mo**

17. (a) **Burial** (b) Date thereof **Sept 6-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Eolia Cemetery**

18. (a) Signature of funeral director **T.E. Gooch**

(b) Address **Eolia Mo**

19. (a) **Sept 6** (b) **no**  
(Date received local registrar) (Registering a signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **5**  
year **1946** hour **7** minute **40** A.M.

21. I hereby certify that I attended the deceased from **8-28-46**, 19\_\_\_\_, to **9-5-46**, 19\_\_\_\_  
that I last saw her alive on **Sept. 5**, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary embolism**  
Due to **Cardiac & Circulatory Failure**  
Due to **Old age and generalized deterioration**  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy **111**

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury **0**

23. Signature **Chas H. Lunnell** (M. D. or other) \_\_\_\_\_  
Address **Louisiana Mo** Date signed **9-5-46**

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

RECEIVED  
District Health Officer No. 10  
10:46:29/22  
OCT 14 1946

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 Norman E. Gosch

Licensed Embalmer No. 2342

P. O. Address Edina, 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.