

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43832**

Registrar's No. **5481**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township OR TOWN Kansas City)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 53 Year		d. STREET ADDRESS (If rural, give location) 720 North Prospect	
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital			

3. NAME OF DECEASED a. (First) Bertie b. (Middle) _____ c. (Last) Woods			4. DATE OF DEATH (Month) (Day) (Year) 12-23-1949		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 9-6-1893			9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (State or foreign country) Fort Worth Texas			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Burton Heath		13b. MOTHER'S MAIDEN NAME Minnie Stewart		14. NAME OF HUSBAND OR WIFE Clarence O. Woods	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mr. Clarence O. Woods, 720 N. Prospect	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, athermia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH Nov. 26, 1949	
ANTECEDENT CAUSES		DUE TO (b) Hypertension		10 yrs.	
		DUE TO (c) Coronary Insufficiency		2 yrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov. 26, 1949, to Dec. 23, 1949, that I last saw the deceased alive on Dec. 20, 1949, and that death occurred at 12:25 A.M., from the causes and on the date stated above.

23a. SIGNATURE Glenn W. Springer (Degree or title) D.O.		23b. ADDRESS 5902 St. John Ave. Kansas City, Mo.		23c. DATE SIGNED 12-29-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-27-1949		24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	
		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri			

DATE REC'D BY LOCAL REG. 12-27-49		REGISTRAR'S SIGNATURE Sheldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. C.L. Forster, K.C. Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed..... *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address *K. C., 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.