

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

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) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City Mo 2150	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) 1323 E 9th	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 1323 E 9th Street			

3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) E.		c. (Last) Wooden		4. DATE OF DEATH (Month) (Day) (Year) March 24-1950					
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single (1)		8. DATE OF BIRTH June 15-1867		9. AGE (In years last birthday) 82		10. MONTHS 9	11. DAYS 9	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) Boonville Missouri		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Myron Wooden		13b. MOTHER'S MAIDEN NAME Laura Ann Maple		14. NAME OF HUSBAND OR WIFE _____		
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 Mrs Maude Wooden		
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 2 days

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		DUE TO (b) Myocardial insufficiency		DUE TO (c) Chronic myocarditis.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility and malnutrition			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 490x		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 **3-2**, 1950, to **3-27**, 1950, that I last saw the deceased alive on **3-27**, 1950, and that death occurred at **4:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE C. B. Wright		23b. ADDRESS P.O. 1777 Independence Ave.		23c. DATE SIGNED 3/24/50	
24a. BURIAL CREMATION REMOVAL (Specify) Burial		24b. DATE 3/25/50		24c. NAME OF CEMETERY OR CREMATORY Coloma	
24d. LOCATION (City, town, or county) (State) Tina Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Clifford W. Quisenberry			

DATE REC'D BY LOCAL REG. 3-24-50		REGISTRAR'S SIGNATURE Seraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Clifford W. Quisenberry	
				ADDRESS Tina Mo.	

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 _____

Clifford W. Austin

Licensed Embalmer No. 3233

P. O. Address Tina D

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.