

FILED JAN 25 1951

## STANDARD CERTIFICATE OF DEATH

State File No. 3504

BIRTH NO. _____		REG. DIST. NO. 334		PRIMARY REG. DIST. NO. 6123		Registrar's No. 105	
1. PLACE OF DEATH a. COUNTY SHANNON				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo. b. COUNTY SHANNON 1014			
b. CITY OR TOWN WINONA RURAL, BOWLIN		c. LENGTH OF STAY (in this place) 43 yrs		c. CITY OR TOWN WINONA RURAL Township Bowlin			
d. FULL NAME OF HOSPITAL OR INSTITUTION WINONA RURAL BOWLIN TOWNSHIP				d. STREET ADDRESS (If rural, give location) WINONA, RURAL, BOWLIN,			
3. NAME OF DECEASED (Type or Print) MAMIE			a. (First) NEVA		b. (Middle) WOODWORTH		c. (Last)
4. DATE OF DEATH		(Month) JAN		(Day) 18		(Year) 1951	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH MAY 5, 1907		9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months 8
IF UNDER 1 YEAR Days 13	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Mo. U		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME WARREN Bland			13b. MOTHER'S MAIDEN NAME HATTIE Huff		14. NAME OF HUSBAND OR WIFE James Andrew Woodworth		
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. —		17. INFORMANT'S SIGNATURE OR NAME ADDRESS J.A. Woodworth Winona			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 332X					INTERVAL BETWEEN ONSET AND DEATH 77 hrs.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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) Winona, Bowlin SHANNON MO			
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 JAN 15, 1951, to JAN 17, 1951, that I last saw the deceased alive on JAN 17, 1951, and that death occurred at 1030 A.M., from the causes and on the date stated above.							
23a. SIGNATURE C.E. Sharp (Degree or title) M.D.				23b. ADDRESS Winona, Mo.		23c. DATE SIGNED JAN 22-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) 1)		24b. DATE 1-20-51	24c. NAME OF CEMETERY OR CREMATORY Blue Bell		24d. LOCATION (City, town, or county) (State) Shannon Mo		
DATE REC'D BY LOCAL REG. 1-22-51		REGISTRAR'S SIGNATURE Mabel Rees		447		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

JAN 24 1951

DISTRICT HEALTH OFFICE No. 6

Title No. ....

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.