

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21490**

BIRTH NO. **36824** REG. DIST. NO. **278** PRIMARY REG. DIST. NO. **3054** Registrar's No. **56**

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

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY PIKE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LOUISIANA		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ASHBURN OF 21	
c. LENGTH OF STAY (in this place) 24 HOURS		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION MINERAL SPRING HOSPITAL			

3. NAME OF DECEASED (Type or Print) CLARENCE WILLIAM WOODSON JR.	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) JUNE 21, 1952
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JUNE 9, 1952	9. AGE (in years last birthday) 19	IF UNDER 1 YEAR Days 19	IF UNDER 6 HRS. Hours 	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) KANSAS CITY, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CLARENCE WILLIAM WOODSON SR.	13b. MOTHER'S MAIDEN NAME NADINE WEATHERBY	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Clarence W. Woodson SR.	ADDRESS ASHBURN, MO.
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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 ONE WEEK
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) THRUSH		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) MALNUTRITION		
	DUE TO (c)		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **JUNE 20, 1952**, to **JUNE 21, 1952**, that I last saw the deceased alive on **JUNE 21, 1952**, and that death occurred at **7:00 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE G. L. Bilyea	(Degree or title) DO.	23b. ADDRESS LOUISIANA, MO.	23c. DATE SIGNED JUNE 21, 52
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE June 23, 1952	24c. NAME OF CEMETERY OR CREMATORY Riverview Cem. Louisiana, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. June 23, 52	REGISTRAR'S SIGNATURE Berniece Collier	374	25. FUNERAL DIRECTOR'S SIGNATURE Halcy Mortuary, Louisiana, Mo.	ADDRESS
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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

Geo. M. Callier

Licensed Embalmer No. 3839

P. O. Address Louisiana, 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.