No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43160

FILED DEC 22 1952

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 293

883
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY: Randolph
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 213 Union

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Randolph
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly 0883
d. STREET ADDRESS (If rural, give location): 213 Union

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): K.
c. (Last): Woods

4. DATE OF DEATH (Month) (Day) (Year): Dec 11th 1952

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sep. 8th 1881
9. AGE (In years last birthday): 71 — If under 1 year: Months 3, Days 3 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rtd Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Brown Shoe Co
11. BIRTHPLACE (City and State or Foreign Country): Mo
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Wm Woods
13b. MOTHER'S MAIDEN NAME: Frances Lay
14. NAME OF HUSBAND OR WIFE: Mollie

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.: 491-07-0777
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Mrs. W. K. Woods, Moberly

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Thrombosis	4 yrs
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cardiac Insufficiency	6 yrs
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: 4343
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1947, *to* 7th, 1952, *that I last saw the deceased alive on* _____ 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. J. Hammond D.C.
23b. ADDRESS: Moberly Mo
23c. DATE SIGNED: 12/12/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-13-52
24c. NAME OF CEMETERY OR CREMATORY: Oakland
24d. LOCATION (City, town, or county) (State): Moberly, Mo

DATE REC'D BY LOCAL REG.: 12/13/52
REGISTRAR'S SIGNATURE: Leah Williams Lowe
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Mahan and Son, Moberly, Mo

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(Licensed Embalmer's Statement on Reverse Side)

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 Frank D. DeHart

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.