

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **599**
 Registrar's No. **22**

FILED FEB 10 1953

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass	
b. CITY OR TOWN Harrisonville		c. CITY OR TOWN Harrisonville	
c. LENGTH OF STAY (In this place) 3 wks		d. STREET ADDRESS (If rural, give location) 207 E. Wall St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital			
3. NAME OF DECEASED a. (First) ANNIE b. (Middle) ELIZABETH c. (Last) WOOLDRIDGE			4. DATE OF DEATH (Month) (Day) (Year) Feb 1 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 3 - 1867
9. AGE (In years) 85	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Harrisonville Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Sylvester Jackson Jones		13b. MOTHER'S MAIDEN NAME Parissa Judy	
14. NAME OF HUSBAND OR WIFE R. L. Wooldrige			
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 S. Wooldrige		ADDRESS Harrisonville Mo	
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) PULMONARY OEDEMA ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CHR. MYOCARDITIS DUE TO (c) CARDIAC COLLAPSE II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. SHOCK FROM A FAN	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4222 F	
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) (Min)		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 21, 1953 , to 21, 1953 , that I last saw the deceased alive on 21, 1953 and that death occurred at 3:15 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE David A. Long, M.D. (Degree or title)		23b. ADDRESS HARRISONVILLE MO	
23c. DATE SIGNED 2/3-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb 3 - 1953	
24c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		24d. LOCATION (City, town, or county) (State) Harrisonville Mo	
DATE REC'D BY LOCAL REG Feb 3 1953		REGISTRAR'S SIGNATURE Dora Barward ADDRESS 457 70	
FUNERAL DIRECTOR'S SIGNATURE Spunnenburgis		ADDRESS Harrisonville Mo	

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

171-0



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 James R. Phillips

Licensed Embalmer No. 4641

P. O. Address Harrisonville, 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.