

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13593**

FILED MAY 11 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **70** PRIMARY REG. DIST. NO. **4124** Registrar's No. **35**

1. PLACE OF DEATH a. COUNTY <b>Clarke</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Iowa</b> b. COUNTY <b>Lee</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kukule</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>818 1/2 Fulton 8140</b>	
c. LENGTH OF STAY (in this place) <b>2 months</b>		d. STREET ADDRESS (If rural, give location) <b>Kukule Iowa</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ward Nursing Home</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Emma</b> b. (Middle) <b>May</b> c. (Last) <b>Wood</b>			4. DATE OF DEATH <b>4-28-53</b> (Month) (Day) (Year)		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>3-25-1970</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Odell, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>Fisher Camp</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Ann Farage</b>	14. NAME OF HUSBAND OR WIFE <b>Willie E Wood</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Verma Wood Meyer</b>	ADDRESS <b>818 1/2 Fulton</b>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>bronchial</b>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pneumonia</b>		
	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 <b>491x</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 **4/27**, 19**53**, to **4/28**, 19**53**, that I last saw the deceased alive on **4/28**, 19**53**, and that death occurred at **6:15** m., from the causes and on the date stated above.

23a. SIGNATURE <b>A. B. Briggs MD</b> (Degree or title)	23b. ADDRESS <b>5000 1/2 S. 5th St</b>	23c. DATE SIGNED <b>5/8-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4-28-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial</b>	24d. LOCATION (City, town, or county), (State) <b>Kokkuk Iowa</b>
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DATE REC'D BY LOCAL REG. <b>5/8-53</b>	REGISTRAR'S SIGNATURE <b>A. B. Briggs</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. M. Joy</b>	ADDRESS <b>Kokkuk, Iowa</b>
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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 \_\_\_\_\_

*myself*

Student Embalmer No. \_\_\_\_\_

Working under my personal supervision.

Student .....  
Student Embalmer

Signed *Robert Long* \_\_\_\_\_

Licensed Embalmer No. *4519* \_\_\_\_\_

P. O. Address *Wentworth Iowa* \_\_\_\_\_

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.