

FILED AUG 18 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27859  
3419

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY OR TOWN <b>KANSAS CITY</b>	c. LENGTH OF STAY (in this place) <b>50 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5000 OAK STREET TWIN OAKS APARTMENTS</b>		f. STREET ADDRESS (If rural, give location) <b>5000 OAK STREET 3124 TWIN OAKS APARTMENTS</b>	
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3. NAME OF DECEASED (Type or Print)	a. (First) <b>FRED</b>	b. (Middle) <b>OSCAR</b>	c. (Last) <b>WOOD</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JULY. 14. 1954</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN. 16. 1893</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>ICE SERVICE CO.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>HARTVILLE MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JAMES THOMAS WOOD</b>	13b. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH SMITH</b>	14. NAME OF HUSBAND OR WIFE <b>CLEO H. 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>513-14-2256</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Cleo H. Wood</b>	ADDRESS <b>5000 OAK ST. KANSAS CITY MO.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adenocarcinoma of rectum</b>		
	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.			<b>1547</b>

19a. DATE OF OPERATION <b>Jan 1954</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21. 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 1947 to 7-14- 1954, that I last saw the deceased alive on 7-14- 1954, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE <b>E. W. Johnson Jr. MD</b>	Degree or title <b>MD</b>	23b. ADDRESS <b>231 W 47 St</b>	23c. DATE SIGNED <b>7-15-54</b>
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24a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>JULY 15 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAN CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>7-16-54</b>	REGISTRAR'S SIGNATURE <b>Seraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. Newsome</b>	ADDRESS <b>331 BRUSH CREEK KANSAS CITY, MO.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed.....  
*Robert Kerr*

Licensed Embalmer No.....*48*

P. O. Address.....*A.C.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.