

FILED OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30923**  
4284  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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 (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (In this place) <b>45 Yrs.</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>2246 East 68th Street</b>				e. STREET ADDRESS (If rural, give location) <b>2246 East 68th Street 2878</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>SALLIE</b>			b. (Middle) <b>MILLIE</b>		c. (Last) <b>WOOD</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 6, 1954</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Jan. 5, 1883</b>		9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Collin County, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>James C. Vance</b>			13b. MOTHER'S MAIDEN NAME <b>Willie Ann Lovelady</b>		14. NAME OF HUSBAND OR WIFE <b>Ben G. Wood</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Ben G. Wood</b>		ADDRESS <b>Kansas City, Mo.</b>	
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) <b>LEFT CEREBRAL ILLUSION</b>						INTERVAL BETWEEN ONSET AND DEATH <b>11 mo.</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>332X</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION _____					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) _____ m.		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 <b>4-28</b> , <sup>1954</sup> to <b>9-6</b> , 1954, that I last saw the deceased alive on <b>9-1-</b> , 1954, and that death occurred at <b>1:09</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>P. C. Quisgard</b> (Degree or title)				23b. ADDRESS <b>6244 Puryear K.C. Mo.</b>		23c. DATE SIGNED <b>9-7-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9-8-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>		24d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>		(State) _____
DATE REC'D BY LOCAL REG. <b>9-7-54</b>		REGISTRAR'S SIGNATURE <b>Neva Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Freeman Mortuary</b>		ADDRESS <b>Kansas City, Mo.</b>	

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

*Mr. Quistgaard*  
*6741 Prospect*  
*1-4*

**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 *J. Freeman*.....

Licensed Embalmer No. *29*.....

P. O. Address *K. O. S.*.....

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.