

FILED DEC 9 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37675**
5409

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hospital		d. STREET ADDRESS (If rural, give location) 200 W. Armour	

3. NAME OF DECEASED (Type or Print) a. (First) CLAUDIA	b. (Middle)	c. (Last) WOODWORTH	4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1954
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Apr. 26, 1870	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MRS. Hours	IF UNDER 1 MRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AtuHomeife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Indiana	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Ira B. Woodworth	13b. MOTHER'S MAIDEN NAME Rose Church	14. NAME OF HUSBAND OR WIFE never married
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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) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Irene Dorland	ADDRESS FA. 5617
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2040
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic lymphocytic Leukemia		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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 Patrol 19 to 19, that I last saw the deceased alive on 11-10-54 and that death occurred at 9:50 P. m., from the causes and on the date stated above.

23a. SIGNATURE Jack H. Hill (Degree or title) M.D.	23b. ADDRESS 3001 Wyandotte St. Kansas City, Mo.	23c. DATE SIGNED 22 Nov 54
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Nov. 21, 1954	24c. NAME OF CEMETERY OR CREMATORY Elmwood	24d. LOCATION (City, town, or county) (State) Kansas City Missouri
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DATE REC'D BY LOCAL REG. 11-23-54	REGISTRAR'S SIGNATURE Neva Minshall	25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE, Kansas City, Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. J. B. Caswell
4000 Baltimore
Va 5115

Apr. 2:00 PM

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 J. S. Walton

Licensed Embalmer No. 2744

P. O. Address K. C. M.

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.