

FILED JUN 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20819

State File No.

BIRTH NO. _____ REG. DIST. NO. 387 PRIMARY REG. DIST. NO. 4497 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <u>SHELBY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>	
b. CITY OR TOWN <u>CLARENCE</u>	c. LENGTH OF STAY (in this place) <u>19 YRS</u>	c. CITY OR TOWN <u>CLARENCE</u>	d. In Residence within limits of a city or incorporated town? Yes <u>A</u> No <u>B</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CLARENCE MO</u>		f. STREET ADDRESS (If rural, give location) <u>CLARENCE MO</u>	

3. NAME OF DECEASED (Type or Print) a. (First) D b. (Middle) O c. (Last) WOOD

4. DATE OF DEATH (Month) (Day) (Year) JUNE 14 1955

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH OCT 11 1879 9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 10b. KIND OF BUSINESS OR INDUSTRY FARMING 11. BIRTHPLACE (City and State or Foreign Country) MONROE CO MO 12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME CALE WOOD 13b. MOTHER'S MAIDEN NAME AMANDA WILSON 14. NAME OF HUSBAND OR WIFE CLARA WOOD

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. 488-18-5112 17. INFORMANT'S SIGNATURE OR NAME CLARA WOOD ADDRESS CLARENCE MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 15 min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary artery disease 18 days +

DUE TO (c) arteriosclerosis 2 yrs +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Obesity 4201

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 1-12 1953, to 6-14 1955, that I last saw the deceased alive on 6-11 1955, and that death occurred at 3:30 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Blair K Hull D.O. 23b. ADDRESS Clarence, Mo 23c. DATE SIGNED 6-16-55

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 6-16-55 24c. NAME OF CEMETERY OR CREMATORY PHILLIPS CEMETERY 24d. LOCATION (City, town, or county) (State) MONROE COUNTY MO

DATE REC'D BY LOCAL REG. 6-20-55 REGISTRAR'S SIGNATURE Ada Garrison 419 25. FUNERAL DIRECTOR'S SIGNATURE Charles V. Sherry ADDRESS Clarence Mo

(Licensed Embalmer's Statement on Reverse Side)

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

APR 30 195

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 *Charles V. Green*.....

Licensed Embalmer No. *46*.....

P. O. Address *Chen*.....

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.