

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25423**

FILED AUG 29 1955

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **894**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (In this place) 8 Days	c. CITY OR TOWN St. Joseph,	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 State Hospital # Two		e. STREET ADDRESS (If rural, give location) 2814 Monterey Street, 01178	

3. NAME OF DECEASED (Type or Print) a. (First) Landon b. (Middle) Chambers c. (Last) Wood, Jr.	4. DATE OF DEATH (Month) (Day) (Year) August 17th 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH August 24th 1919	9. AGE (In years last birthday) 35 Yrs	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) Never employed-	10b. KIND OF BUSINESS OR INDUSTRY Invalid	11. BIRTHPLACE (City and State or Foreign Country) Havana, Cuba.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Landon C. Wood, Sr.	13b. MOTHER'S MAIDEN NAME Mildred Thomas	14. NAME OF HUSBAND OR WIFE none
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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 2814 ADDRESS Mr. Landon C. Wood, Sr. (Father) Monterey.
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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 2 Days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Status Epilepticus		Chronic
	ANTECEDENT CAUSES DUE TO (b) Encephalitis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Chronic Brain Syndrome Epilepsy		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychotic		Recent.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 **Aug 9th, 1955**, to **Aug 17, 1955**, that I last saw the deceased alive on **Aug 17, 1955**, and that death occurred at **11:55 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C.E. Gossin M.D.	23b. ADDRESS State Hospital # Two, City	23c. DATE SIGNED 8-17-1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) (Burial)	24b. DATE 1955 August 20th	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. Aug 22, 1955	REGISTRAR'S SIGNATURE Cather M. Allison 485	25. FUNERAL DIRECTOR'S SIGNATURE Weinbauer Oleman	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Albert B. Harrington*

Licensed Embalmer No..... 3258

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