

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37096**
5041

FILED DEC 6 1955

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 town) Kansas City		c. CITY OR TOWN Osceola	
c. LENGTH OF STAY (in this place) 1 Day		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph's Hospital		STREET ADDRESS (If rural, give location) 0920	

3. NAME OF DECEASED (Type or Print) a. (First) Elmer	b. (Middle) S.	c. (Last) Wood	4. DATE OF DEATH (Month) (Day) (Year) Nov 20 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar 13 1888	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	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) Retired	10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME OLLIE WOOD	13b. MOTHER'S MAIDEN NAME JANE PATES	14. NAME OF HUSBAND OR WIFE Daisy Wood
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 500-05-6898	17. INFORMANT'S SIGNATURE OR NAME Hospital Records	ADDRESS Kansas City, Mo
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute Peritonitis		INTERNAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Ruptured Duodenal Ulcer		
	DUE TO (c) Chronic		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		5411

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)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE H. Frank Holman (Degree or title)	23b. ADDRESS St Joseph Hosp	23c. DATE SIGNED 11-20-55
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24a. REMOVAL (Specify) Removed	24b. DATE 11-21-55	24c. NAME OF CEMETERY OR CREMATORY Osceola Cem.	24d. LOCATION (City, town, or county) (State) Osceola, Mo.
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DATE REC'D BY LOCAL REG. 11-20-55	REGISTRAR'S SIGNATURE Neve Marshall	25. FUNERAL DIRECTOR'S SIGNATURE D.W. Newcomer's Sons	ADDRESS 1321 S. 2nd St., Mo.
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WRITE PLAINLY—USING UNFAADING 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 *Adrian Jay Stitt*

Licensed Embalmer No. *48*

P. O. Address *N.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.