

FILED JUN 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20803**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2710

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 OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 46 YEARS		e. STREET ADDRESS (If rural, give location) 4002 NORTON AVENUE 3608	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4002 NORTON AVENUE			

3. NAME OF DECEASED (Type or Print) FLOSSIE	a. (First) B.	b. (Middle) WOODS	c. (Last) WOODS	4. DATE OF DEATH (Month) (Day) (Year) MAY 24 1956
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPTEMBER 17, 1897	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.	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) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) CORYDON, IOWA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME DANIEL K. BARKER	13b. MOTHER'S MAIDEN NAME SYRAN STEWART	14. NAME OF HUSBAND OR WIFE EDWARD J. WOODS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME EDWARD J. WOODS	ADDRESS 4002 NORTON, K. C. 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asymptomatic Lateral Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs
	ANTECEDENT CAUSES - Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____		
	DUE TO (c) Psychoneurosis		
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)	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 8:30, 1955, to 24 May, 1956, that I last saw the deceased alive on 23 May, 1956 and that death occurred at 9:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE J. B. Willoughby M.D. (Declarer or title)	23b. ADDRESS 5905 Main K C 13 Mo	23c. DATE SIGNED 25 May 56
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24a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 26, 1956	24c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 5-25-56	REGISTRAR'S SIGNATURE Neva Mindhall	25. FUNERAL DIRECTOR'S SIGNATURE D. W. Newcomer's Sons	ADDRESS Kansas City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
J. B. Willoughby M.D.

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 *Everett L. Seed*.....

Licensed Embalmer No. *485*

P. O. Address *Kansas*

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.