

FILED FEB 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

246

STATE FILE NUMBER

13491-56 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 45

1. PLACE OF DEATH a. COUNTY BOONE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CAMDEN					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN COLUMBIA		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN MARK'S CREEK		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIVERSITY, MO			Length of stay in 1b 3 Months 24 days		d. STREET ADDRESS (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE Woodall				4. DATE OF DEATH Month Day Year 2 3 57					
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-56		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 10 17		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) JEFFERSON CITY, MO.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME EZEKIEL CLARENCE Woodall				14. MOTHER'S MAIDEN NAME WANDA McGUIRE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Record				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE (TRANSPOSITION OF GREAT VESSELS) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH since bmt	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from MAR 10 20, 1956 and last saw him alive on FEB 2, 1957 Death occurred at 2:00 AM m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Clarence R. Pollock MD				22b. ADDRESS U. of Missouri, Columbia			22c. DATE SIGNED 2/3/57		
23a. BURIAL OR CREMATION REMOVAL (Specify)		23b. DATE Feb. 3, 1957		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City, town, or county) Buffalo, Mo.		(State)	
24. FUNERAL DIRECTOR L. B. Jones			ADDRESS Buffalo, Mo.		25. DATE RECD. BY LOCAL REG. Feb 3 1957		26. REGISTRAR'S SIGNATURE Mrs. R. E. Palmer		

FEB 18 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{was} ~~was~~ by me, or by, Student Embalmer No. working under my personal supervision...

Student
Signature of Student Embalmer

Signed *L. B. Jones*

Licensed Embalmer No.

P. O. Address *Buffalo*

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