

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5236

STATE FILE NUMBER

FILED MAR 5 1957

Registration District No. 61 Primary Registration District No. 5236 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <i>Cedar</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cedar</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Box Top</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>El Dorado Spgs</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Home</i> Length of stay in lb		d. STREET ADDRESS <i>RFD # 5</i> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>JOHN T WOOD</i> First Middle Last			4. DATE OF DEATH <i>2-27-57</i> Month Day Year		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 20 1887</i>	9. AGE (In years last birthday) <i>69</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dr. Kalb Co Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wood</i>			14. MOTHER'S MAIDEN NAME <i>Delphine Worden</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>497-12-6543</i>		17. INFORMANT <i>Ann Myrtle Wood</i> Address <i>El Dorado Spgs Mo</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Coronary arteriosclerosis</i>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <i>4201</i>	
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 checked="" 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 <i>1-1-57</i> to <i>2-27-57</i> and last saw <i>him</i> alive on <i>2-27-57</i> Death occurred at <i>9:05 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <i>Robert L. Magee M.D.</i>	22b. ADDRESS <i>El Dorado Springs, Mo.</i>	22c. DATE SIGNED <i>3-1-57</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	23b. DATE <i>3-3-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Coal Hill</i>	23d. LOCATION (City, town, or county) (State) <i>Cedar Co Mo</i>
24. FUNERAL DIRECTOR ADDRESS <i>Magee, El Dorado Spgs Mo</i>		25. DATE RECD. BY LOCAL REG. <i>3-2-57</i>	26. REGISTRAR'S SIGNATURE <i>George W. Magee</i>

Health, Welfare, Public Service
300-1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAY 28 1957

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 *Hugh S. Allen*.....

Licensed Embalmer No. *28*

P. O. Address *Ed. Donahoe*

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.