

FILED MAY 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13501
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1808

3008
800
1-57

Health, Welfare & Public Service
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.

H.P. Boughnour
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Passio Nursing Home</u>		Length of stay in lb <u>45 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>4837 Campbell</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FAY</u> Middle <u>D.</u> Last <u>WOODWARD</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1877</u>
9. AGE (In years last birthday) <u>79</u>		10. MONTHS <u>1</u> DAYS <u>1</u>	11. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Sweet Springs, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>ROBERT BRADY</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Claude Woodward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Fawn Nette</u> Address <u>MRS. NETTE MOORE, 4837 CAMPBELL ST.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Cerebral.</u> DUE TO (b) <u>General Arteriosclerosis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. INTERVAL BETWEEN ONSET AND DEATH <u>334 h</u>		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.)	
20c. TIME OF INJURY Hour _____ 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.) <u>4/24/55</u>		20f. CITY, TOWN, OR LOCATION <u>4/15/57</u> COUNTY _____ STATE _____	
21. I attended the deceased from <u>4/24/55</u> to <u>4/15/57</u> and last saw her/him alive on _____ Death occurred at <u>7:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>H.P. Boughnour M.D.</u>	
22b. ADDRESS <u>Kansas City, Mo.</u>		22c. DATE SIGNED <u>4/16/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 17, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>
23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>		24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons K.C., Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>4-17-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>	

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 *Paul H. Williamson*

Licensed Embalmer No. *5009*

P. O. Address *Overland Park, 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.