

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**38959**  
STATE FILE NUMBER  
Registration District No. 359 Primary Registration District No. 4525 Registrar's No. 18

FILED NOV 4 1957

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milo</u> <u>Milo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Milo</u> <u>1080</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>main part of</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>main part of Milo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Wesley Woodard</u>			4. DATE OF DEATH Month Day Year <u>Oct. 16 - 1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1887</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months Days <u>3 23</u>	IF UNDER 24 HRS. Hours Min. <u>+</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Morrisville Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Melvin M. Woodard</u>	
13b. MOTHER'S MAIDEN NAME <u>Caldona Mitchell</u>		14. NAME OF HUSBAND OR WIFE <u>Althea Woodard</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 Address <u>Mar. J. W. Woodard Milo Mo.</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>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Previous hypertension &amp; Cerebral Hemorrhage</u>			<u>Oct 4 - 1957 to Oct 16 - 1957.</u>
DUE TO (c) _____			<u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>31X</u>	
20c. TIME OF INJURY . Hour Month, Day, Year a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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>Nevada - Vernon - Mo</u>	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>7:20</u> <u>Oct 8/57</u> to <u>Oct 16/57</u> and last saw him alive on <u>Oct 8/57</u> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. J. Woodard</u> (Degree or title) <u>0</u>		22b. ADDRESS <u>Nevada Mo</u>	
22c. DATE SIGNED <u>10/17/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 19, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burwood cemetery</u>
23d. LOCATION (City, town, or county) <u>Balilar Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Ernie Blue</u> ADDRESS <u>Balilar Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 28 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ruth Faith</u>

securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Willard B. Erwin* .....

Licensed Embalmer No. *3092* .....

P. O. Address *Bolivar, Mo.* .....

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.