

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 - 1957

40679

STATE FILE NUMBER

5107

Registration District No. 149

Primary Registration District No. 1005

Registrar's No.

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|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Jackson</i>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Mo.</i> b. COUNTY <i>Cedar</i>                     |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><i>HC Hanna City</i><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |   | c. CITY OR TOWN <i>El Dorado Springs</i><br>Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>                                      |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br><i>Research Hosp.</i><br>Length of stay in lb <i>2 days</i>  |   | d. STREET ADDRESS (If outside, give location)<br><i>401 Forest</i><br>Rural on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) First <i>Alexander</i> Middle <i>-</i> Last <i>Woods</i>   |   | 4. DATE OF DEATH<br>Month <i>Oct</i> Day <i>31</i> Year <i>57</i>   |   |
| 5. SEX <i>Male</i>  | 6. COLOR OR RACE <i>white</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        | 8. DATE OF BIRTH<br><i>Aug. 31, 1889</i>  |
| 9. AGE (In years last birthday) <i>68</i>   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>retired laborer</i>                                    |   |
| 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)<br><i>St. Clair Co., Mo.</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |   |
| 13a. FATHER'S NAME<br><i>James Woods</i>  |   | 13b. MOTHER'S MAIDEN NAME<br><i>Julia Abie Carnes Susie</i>   |   |
| 14. NAME OF HUSBAND OR WIFE<br><i>Susie</i>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><i>No</i>   |   |
| 16. SOCIAL SECURITY NO.<br><i>unk.</i>  |   | 17. INFORMANT<br><i>Carl Welliver 1821 E 76<sup>th</sup> KC Mo.</i>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Bullet wound of head</i>                                    |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |   |   | <i>8976X</i>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><i>Self Inflicted</i>       |   |   |
| 20c. TIME OF INJURY<br>Hour <i>10:30</i> Month <i>Nov</i> Day <i>1</i> Year <i>57</i><br>a.m. p.m.  | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><i>Home</i>                     |   |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   | 20f. CITY, TOWN, OR LOCATION<br><i>El Dorado Springs, Cedar, Mo.</i><br>COUNTY <i>Hanna City Jackson Mo</i> STATE <i>MO</i> |   |   |
| 21. I attended the deceased from _____ to _____ and last saw him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE<br><i>Hugh H. Owens Coroner</i><br>(Degree or title) <i>3</i>  |   | 22b. ADDRESS<br><i>1034 Briarh Bldg</i>   |   |
| 22c. DATE SIGNED<br><i>11-57</i>  |   | 23. NAME OF CEMETERY OR CREMATORY<br><i>Clintonville</i>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><i>removal</i>  | 23b. DATE<br><i>Nov. 1, 1957</i>  | 23d. LOCATION (City, town, or county) (State)<br><i>El Dorado Springs Mo.</i>   |   |
| 24. FUNERAL DIRECTOR<br><i>Quinn Goethers H.</i><br>ADDRESS<br><i>El Dorado Springs Mo.</i>   |   | 25. DATE RECD. BY LOCAL REG.<br><i>11-1-57</i>  |   |
| 26. REGISTRAR'S SIGNATURE<br><i>newa minshall</i>   |   |   |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Hugh H. Owens

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.



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 *John R. Sidman*

Licensed Embalmer No. *4531*

P. O. Address *W. C. 720*

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.