

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43893

STATE FILE NUMBER

FILED DEC 24 1957

Registration District No. 88 Primary Registration District No. 5325 Registrar's No. 37

S. 300  
v. 1-56

Special manner required by 193.140 MO RS 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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Crawford</u>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>Berryman</u>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY<br>OR<br>TOWN <u>Berryman</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <u>25 mi. E. on hwy 8</u>   |                                  | Length of stay in lb<br><u>28 yrs.</u>  | d. STREET<br>ADDRESS<br>(If outside, give location)  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print) <u>Richard R. Wood</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>9</u> Year <u>57</u>  |  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-28-81</u>   | 9. AGE (In years last birthday)<br><u>76</u>                                 | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>11</u> Hours <u></u> Min. <u></u>                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer Retired</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><u>Flat River, Mo.</u>         | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |
| 13. FATHER'S NAME<br><u>William Wood</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Jennie Midyett</u>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, cite war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br>Address<br><u>Walter Wood 5611 Riverview St. Louis, Mo.</u> |   |
| 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) <u>Due to a heart attack</u>                                       |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 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)  |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a. m. _____<br>p. m. _____   |                                  |   |  |  |   |
| 20d. INJURY OCCURRED<br>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<br>COUNTY _____ STATE _____                     |   |
| 21: I attended the deceased from _____ to _____ and last saw her/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><u>Harry M. Jonas</u> (Degree or title) <u>3</u>  |                                  |   | 22b. ADDRESS<br><u>Steelville, Mo.</u>   |  | 22c. DATE SIGNED<br><u>12-13-57</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE<br><u>12-14-57</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Upper Indian Creek</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>Viburnum Mo.</u>                              |
| 24. FUNERAL DIRECTOR<br><u>Harry M. Jonas</u>   |                                  | ADDRESS<br><u>Steelville, Mo.</u>   |  | 25. DATE RECD. BY LOCAL REG.<br><u>11/20/57</u>                              | 26. REGISTRAR'S SIGNATURE<br><u>Mrs. Hazel Lichius</u>  |

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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 Robert Parker Roach Student Embalmer No. 59 working under my personal supervision..

Student Robert Parker Roach Signature of Student Embalmer Signed Harry M. Jones

Licensed Embalmer No. 262

P. O. Address Steely

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.