

Health, & Welfare  
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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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025218

STATE FILE NUMBER

FILED AUG 11 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 766

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u> 0396	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>921 E. Lombard</u>		Length of stay in lb <u>20 yrs.</u>	
d. STREET ADDRESS <u>921 E. Lombard</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Salern</u> Middle <u>----</u> Last <u>Woods</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>2,</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> UNMARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1903</u>
9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>55</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe repairman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Shop</u>
11. BIRTHPLACE (City and state or country) <u>Belmont, Neb.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	13a. FATHER'S NAME <u>Robert M. Woods</u>	13b. MOTHER'S MAIDEN NAME <u>Yettie Valera Funk</u>
14. NAME OF HUSBAND OR WIFE <u>Ruth Woods-Springfield, Mo.</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>500-36-6440</u>	16. SOCIAL SECURITY NO. <u>500-36-6440</u>	17. INFORMANT Address <u>Ruth Woods-Springfield, Missouri</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>4 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>			DUE TO (c) <u>5 yrs</u>
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? 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 <u>10:30</u> Month, Day, Year a.m. <u>P. M.</u> p.m.	20d. INJURY OCCURRED WHILE AT <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 <u>March 21, 1955</u> to <u>Aug 2, 1958</u> and last saw him alive on <u>Aug 2, 1958</u> Death occurred at <u>10:30 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. D. Callaway, M.D.</u>	22b. ADDRESS <u>Springfield Mo</u>	22c. DATE SIGNED <u>8/7/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-5-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
24. FUNERAL DIRECTOR <u>Rex Rainey-Springfield, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>8-8-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

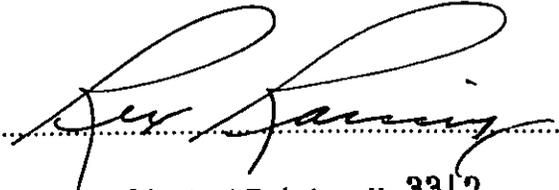
AUG 14 1958

JUN 13 1962

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  \_\_\_\_\_

Licensed Embalmer No. 3312  
P. O. Address Springfield, 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.