

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033102
STATE FILE NUMBER

FILED OCT 8 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4443

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	3500 CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp #1		Length of stay in lb 33 yrs.	d. STREET ADDRESS (If outside, give location) 503 E 104th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Juanita Middle MAE Last Woods			4. DATE OF DEATH Month 9 Day 17 Year 1958		
---	--	--	---	--	--

5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 4, 1924	9. AGE (In years last birthday) 34	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Columbia, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	--	---

13a. FATHER'S NAME Ernest J. Forsee	13b. MOTHER'S MAIDEN NAME Rula Sapp	14. NAME OF HUSBAND OR WIFE Cleve F. Woods
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 500-28-6285	17. INFORMANT R. E. Hedges	Address 503 E. 104th St.
--	---	--------------------------------------	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) healed tuberculosis, pulmonary	
	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? 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.) 0027
---	---

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.)	20f. CITY, TOWN, OR LOCATION Kansas City	COUNTY Jackson	STATE
---	---	--	--	--------------------------	-------

21. I attended the deceased from Sept 13, 1958 to Sept 17, 1958 and last saw her alive on Sept 17, 1958 Death occurred at 6:50 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. I. Burns, M.D.	22b. ADDRESS 24th & Cherry	22c. DATE SIGNED 9-17-58
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 19, 1958	23c. NAME OF CEMETERY OR CREMATORY Mt. Mariah	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
--	------------------------------------	---	--

24. FUNERAL DIRECTOR Gatea Funeral Home	ADDRESS K.C. Kan.	25. DATE RECD. BY LOCAL REG. 9-18-58	26. REGISTRAR'S SIGNATURE Neva Minshall
---	-----------------------------	--	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. I. Burns

MEDICAL CERTIFICATION



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.....

P. O. Address.....

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.