

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036123

STATE FILE NUMBER

FILED NOV 10 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1050

S. 300  
v. 1-57

3

Do not 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

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Burge</b>		Length of stay in lb <b>15 yrs.</b>	d. STREET ADDRESS <b>1901 N. Broad</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES LOFTON WOOD</b>			4. DATE OF DEATH Month Day Year <b>Oct. 31, 1958</b>
5. SEX <b>Male</b> <input type="radio"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1897</b>
9. AGE (In years last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Orthopedic</b>	11. BIRTHPLACE (City and state or country) <b>Oklahoma</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Wood</b>	
13b. MOTHER'S MAIDEN NAME <b>Savannah Murray</b>		14. NAME OF HUSBAND OR WIFE <b>Bonnie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>491-03-1069</b>	17. INFORMANT Address <b>Mrs. B. Wood Springfield, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>UNATTENDED BY A PHYSICIAN</b> DUE TO (c) <b>331X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
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 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 COUNTY STATE	
21. I attended the deceased from <b>Sept 22, 1958</b> and last saw him alive on <b>Sept 22, 1958</b> Death occurred at <b>7:30 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James R. Amos, M.D.</b> (Degree or title)		22b. ADDRESS <b>Greene County Health Officer, Spfld, Mo</b>	
22c. DATE SIGNED <b>11-5-58</b>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 3, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel</b>		23d. LOCATION (City, town, or country) (State) <b>Springfield, Mo.</b>	
24. FUNERAL DIRECTOR <b>Ralph Thieme</b> ADDRESS <b>Springfield, Mo. LM</b>		25. DATE RECD. BY LOCAL REG. <b>11-5-58</b>	
		26. REGISTRAR'S SIGNATURE <b>Effie G. Mellon</b>	

DEC 1956

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 Wayne Smith, Student Embalmer No. 567 working under my personal supervision.

Student Wayne Smith  
Signature of Student Embalmer

Signed Lee Mason

Licensed Embalmer No. 4568

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.