

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036777

STATE FILE NUMBER

FILED OCT 28 1958 Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 444

S. 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 Blue Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Kansas City 22, (Rural) ⁷⁰⁰⁰		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 617 Lake Dr		Length of stay in 1b 31 yrs	d. STREET ADDRESS (If outside, give location) 617 Lake Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Anna O. Womack			4. DATE OF DEATH Month Day Year Oct 17, 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1, 1861	9. AGE (In years last birthday) 91 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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Pawnee, Ill.	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Joseph Ogden		13b. MOTHER'S MAIDEN NAME Mary Ball		14. NAME OF HUSBAND OR WIFE William P. Womack (Deceased)	
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. None	17. INFORMANT Mrs. Dwight Kelso Kansas City 22, Mo. Address		
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>Ventricular fibrillation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Congestive heart failure 4200</u> DUE TO (c) <u>Atherosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 min. onset Oct. 6, 1958</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <u>Chronic cholecystitis + cholelithiasis recently acute. Pyelonephritis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I (a) or PART II (c) of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED 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		COUNTY STATE
21. I attended the deceased from <u>Sept. 21, 1958</u> to <u>Oct. 17, 1958</u> and last saw her alive on <u>Oct. 17, 1958</u> Death occurred at <u>6:45</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Norman Meadows, M.D.</u>			22b. ADDRESS <u>1090 Winner Rd.</u>		22c. DATE SIGNED <u>Oct. 15, 1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Oct. 19, 1958	23c. NAME OF CEMETERY OR CREMATORY Horse Creek Cemetery		23d. LOCATION (City, town, or county) (State) Pawnee, Illinois
24. FUNERAL DIRECTOR Geo. C. Carson Address Indep., Mo.			25. DATE RECD. BY LOCAL REG. 10-19-58		26. REGISTRAR'S SIGNATURE <u>James H. King</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Dean W. Huff*

Licensed Embalmer No. *4914*
P. O. Address *Indy, 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.