

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001862

STATE FILE NUMBER

FILED JAN 13 1959 Registration District No. 163 Primary Registration District No. 5893 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Platin		c. CITY OR TOWN Quilin	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TT Highway		d. STREET ADDRESS (If outside, give location) Route 1	
Length of stay in lb 3 days		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) MANDAILO WOODS			4. DATE OF DEATH Jan 1 1959				
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 Oct. 30, 1885	9. AGE (In years last birthday) 73		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 -----		11. BIRTHPLACE (City and state or country) Bradford, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse McCoy			14. MOTHER'S MAIDEN NAME Annie Razer				
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. Nadine Morice, Route 1, Festus, Mo			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Coronary Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 7
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) 4201		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 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 Hillsboro, Missouri		COUNTY STATE	
21. Attended the deceased Death occurred at 6:00 m on the date stated above; and to the best of my knowledge, from the causes stated.							

22a. SIGNATURE (Degree or title) <i>Carole Rice MD</i> Health Officer			22b. ADDRESS Hillsboro, Missouri			22c. DATE SIGNED 1/11/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Jan 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Gillian Cemetery		23d. LOCATION (City, town, or county) Bloomfield, Mo. (State)		

24. FUNERAL DIRECTOR ADDRESS Watkins Fun'l Home, Dexter, Mo.		25. DATE RECD. BY LOCAL REG. Jan 3-1959		26. REGISTRAR'S SIGNATURE <i>Marie Parria</i>			
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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