Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004644
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 197

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Joseph — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 812 Pacific St. — Length of stay in 1b: 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buch.
c. CITY OR TOWN St. Joseph — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 506 S. 17th St. — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Frank; Middle; Last Woods

4. DATE OF DEATH Month Feb; Day 19; Year 1959

5. SEX Male 2

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ 3 DIVORCED ☒

8. DATE OF BIRTH Mar. 29, 1882

9. AGE (In years last birthday) 76 — 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) Laborer

10b. KIND OF BUSINESS OR INDUSTRY -----

11. BIRTHPLACE (City and state or country) Steinmetz, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unknown

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Welfare Board — Address St. Joseph Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Unk.
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): 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 2/24/58, to 2/19/59 and last saw her/him alive on 2/18/59
Death occurred at 3:40 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S.E. Meluney M.D.

22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.

22c. DATE SIGNED 2/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Feb. 23, 1959

23c. NAME OF CEMETERY OR CREMATORY City Cemetery

23d. LOCATION (City, town, or county) St. Joseph, Missouri (State)

24. FUNERAL DIRECTOR Beatrice Gray — ADDRESS 812 Pacific St

25. DATE RECD. BY LOCAL REG. Feb 24, 1959

26. REGISTRAR'S SIGNATURE Mrs. Clark Stordell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. S.E. Meluney

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 John T. Miles

Licensed Embalmer No. 3446

P. O. Address [illegible]

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.