

Dr. Hall

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005236
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 172

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY TANEY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN FORSYTH 1060
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BAPTIST HOSP.		Length of stay in lb 8 DAYS	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT HADLEY WOODS			4. DATE OF DEATH Month Day Year FEB. 17 1959
5. SEX MALE 0	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. 1 1908
9. AGE (In years last birthday) 50		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) BARBER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ORRICK, MISSOURI 0
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME ANDREW WOODS	
13b. MOTHER'S MAIDEN NAME LOUISE MYERS		14. NAME OF HUSBAND OR WIFE CHRISTINE WOODS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES W.W. # 2		16. SOCIAL SECURITY NO. 495-24-6119	17. INFORMANT Address MRS. CHRISTINE WOODS, FORSYTH, 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) Acute myelomalacia, brain stem and cerebellum			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ruptured aneurysm circle of Willis (base of brain)			3 1/2 days
DUE TO (c) 330x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Recent partial gastrectomy for exsanguinating hemorrhage peptic ulcer duo			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 a.m. Month, Day, Year 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 February 6, 1959 to February 17, '59 and last saw ^{her} him alive on February 17, 1959 Death occurred at 8:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not use title) <i>Dr. Edward G. Hall</i>		22b. ADDRESS 1211 S. Glenstone, Springfield, Mo	22c. DATE SIGNED 2/19/59
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL	23b. DATE 2/21/59	23c. NAME OF CEMETERY OR CREMATORY MASONIC CEMETERY	23d. LOCATION (City, town, or country) (State) EXCELSIOR SPRINGS, MO.
24. FUNERAL DIRECTOR FORSYTH FUNERAL HOME, FORSYTH, MO.		25. DATE RECD. BY LOCAL REG. 2-19-59	26. REGISTRAR'S SIGNATURE <i>Offie E. Melton</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 17 1959

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 *H. M. O. Carr*

Licensed Embalmer No. 2727

P. O. Address *Springer, Va.*

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.