

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006461
STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 231 Primary Registration District No. 4348 Registrar's No. 10

300
-57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellsville</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Wellsville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>512 W. Locust</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>512 W. Locust</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES LEWIS WOODSON</u>			4. DATE OF DEATH Month Day Year <u>Feb. 8, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1875</u>	9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general farming</u>		11. BIRTHPLACE (City and state or country) <u>Callaway Co., Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>James S. Woodson</u>		13b. MOTHER'S MAIDEN NAME <u>Harriet E. Hendricks</u>	
14. NAME OF HUSBAND OR WIFE <u>Emma Munford Woodson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>498-05-9711</u>	
17. INFORMANT Address <u>Mrs. Emma M. Woodson, Wellsville, Mo</u>		18. CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Coronary artery Disease</u> DUE TO (c) <u>Arterio-sclerosis.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>2 years</u> <u>?</u>	
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		COUNTY		STATE	
21. I attended the deceased from <u>10-24-58</u> to <u>2-8-59</u> and last saw ^{her} _{him} alive on <u>2/7/59</u> Death occurred at <u>3:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>J. W. Callaway M.D.</u> (Degree or title)		22b. ADDRESS <u>Wellsville Mo</u>	
22c. DATE SIGNED <u>2/9/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/9/1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wellsville, City</u>		23d. LOCATION (City, town, or county) <u>Wellsville, Mo.</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>A. B. Hills</u>		ADDRESS <u>Wellsville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-10-59</u>	
26. REGISTRAR'S SIGNATURE <u>Laura S. Callaway</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Locality, coroner, etc. must use only standard nomenclature from 10. 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 *Howard Myers*

Licensed Embalmer No. *4494*

P. O. Address *Wellsville, 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.