

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008739

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 28

FILED APR 2 1959

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mission</u> <u>7150</u> <u>8</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Veterans Administration Hospital</u>		Length of stay in lb <u>10 yrs 20 days</u>	d. STREET ADDRESS (If outside, give location) <u>5432 Nall Street</u>
INSTITUTION <u>tion Hospital</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>Edward</u> Last <u>WOODEN</u>			4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>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>Jan. 6, 1895</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Warehouse</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Charles Wooden</u>		13b. MOTHER'S MAIDEN NAME <u>Jeanette Austin</u>		14. NAME OF HUSBAND OR WIFE <u>Hazel Wooden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>486 03 1994</u>		17. INFORMANT <u>VA Hospital records</u>	

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>Emphysema, severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Tuberculosis, pulmonary, far advanced, active</u>			18 years
	DUE TO (c) <u>---</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fibrosis of myocardium, due to arteriosclerotic coronary thrombosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) <u>---</u>		
20c. TIME OF INJURY Hour <u>---</u> Month, Day, Year <u>---</u> a.m. <u>---</u> p.m. <u>---</u>					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY <u>---</u>	STATE <u>---</u>
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21. VA attended the deceased from Jan. 24, 1949 to Mar. 16, 1959
Death occurred at 6:10 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>L. S. Arany</u> <u>L.S. ARANY, M.D., Director, Professional Serv. Excelsior Springs, Mo.</u>	22b. ADDRESS <u>---</u>	22c. DATE SIGNED <u>3-17-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Leavenworth, Kansas</u>
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24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u>	ADDRESS <u>Excelsior Springs, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>3-19-59</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

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 *Popple Van Landingham*

.. Licensed Embalmer No. *4009*
Epstein Springs, 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.