

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012214  
STATE FILE NUMBER

FILED APR 24 1959 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 77

300  
-57

1. PLACE OF DEATH a. COUNTY <b>AUDRAIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>MONROE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MEXICO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>PARIS</b> 0690 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>AUDRAIN COUNTY HOSPITAL</b> INSTITUTION		Length of stay in lb <b>2 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>FAIRVIEW HEIGHTS</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>CAROLINE Y WOOD</b>			4. DATE OF DEATH Month Day Year <b>APRIL 13 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 6, 1870</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. <b>89 2 7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (City and state or country) <b>CABERY ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>ANTHONY YOUNG</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>JOHN W. WOOD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>MRS CLAUDE McFADIN ROUTE 4 MEXICO.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adams-Stokes Syndrome</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Heart Disease</b>		<b>unknown</b>
DUE TO (c) <b>Third degree heart block</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from **4-11-59** to **4-13-59** and last saw her alive on **4-13-59**  
Death occurred at **4:15** p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Ernest S. Yant MD</b>	22b. ADDRESS <b>Mexico, Mo</b>	22c. DATE SIGNED <b>4-14-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/15/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW HOPE</b>	23d. LOCATION (City, town, or county) (State) <b>6 MI S.E. OF PARIS MO.</b>
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24. FUNERAL DIRECTOR <b>E.H. AGNEW SPEED &amp; BAREY FUNERAL HOME</b>	25. DATE RECD. BY LOCAL REG. <b>April 14-1959</b>	26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>
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(Licensed Embalmer's Statement on Reverse Side)

All diagnoses in Part I may be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. MEDICAL CERTIFICATION

ERNEST S. YANT MD

**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 ..... *E. H. Agnew* .....

Licensed Embalmer No. *4000* .....

P. O. Address... *Paris, 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.**