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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-018799
STATE FILE NUMBER

FILED JUN 5 1959

Registration District No. 296 Primary Registration District No. 6018 Registrar's No. 14

1. PLACE OF DEATH
a. COUNTY: Ray
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Excelsior Springs — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: RR#2 — Length of stay in 1b: 7 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Ray
c. CITY OR TOWN: Excelsior Springs — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): RR#2 — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Lillie Middle: Jane Last: Woods

4. DATE OF DEATH Month Day Year: May 21, 1959

5. SEX: Female **6. COLOR OR RACE:** White **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 16, 1925 **9. AGE** (In years last birthday): 33 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): Housewife **10b. KIND OF BUSINESS OR INDUSTRY:**

11. BIRTHPLACE (City and state or country): Excelsior Springs, Mo. **12. CITIZEN OF WHAT COUNTRY?** USA

13a. FATHER'S NAME: Forrest Wood **13b. MOTHER'S MAIDEN NAME:** Lillie May **14. NAME OF HUSBAND OR WIFE:** Gary Woods

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** Address: Mr. Gary Woods, RR#2, Excelsior Springs, 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): Ca. of Cervix c metastasis to pelvis Aug 1958
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 171X
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 11-21-58 to 21 May 59 and last saw her alive on 5-11-59
Death occurred at 8:30 pm 5-21-59 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George E Sanders MD **22b. ADDRESS:** Excelsior Springs, Mo **22c. DATE SIGNED:** 5-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify) **23b. DATE:** 5-23-59 **23c. NAME OF CEMETERY OR CREMATORY:** Crown Hill **23d. LOCATION** (City, town, or county) (State): Excelsior Springs, Mo.

24. FUNERAL DIRECTOR ADDRESS: Prichard Funeral Home, Inc. Excelsior Springs, Missouri **25. DATE RECD. BY LOCAL REG.:** 5-29-59 **26. REGISTRAR'S SIGNATURE:** Helen J Larkin

(Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Chelsea 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.