

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020350

STATE FILE NUMBER

FILED JUN 16 1959

Registration District No. 15 Primary Registration District No. 3004 Registrar's No. 37

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Barton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Vernon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lamar</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Sheldon</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Memorial Hospt</b>		Length of stay in 1b <b>30 min.</b>	d. STREET ADDRESS (If outside, give location) <b>1080</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Edward</b> Last <b>Wood</b>			4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1910</b>
9. AGE (In years last birthday) <b>48</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b>	IF UNDER 24 HRS. Hours <b>14</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Methodist Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lawrence Co. Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Joseph P. Wood</b>	
13b. MOTHER'S MAIDEN NAME <b>Gertrude Jarrett</b>		14. NAME OF HUSBAND OR WIFE <b>Ethel 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>702-10-9221</b>	17. INFORMANT Address <b>Ethel Wood Sheldon, Mo.</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>Cerebral Accident - massive hemorrhage?</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>DUE TO (a)</b> DUE TO (c) 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 <b>one hr (about)</b>
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. _____ 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 <b>at time of this only</b> and last saw her <b>6-7-59</b> alive on _____ Death occurred at <b>12:05</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Herbert M. Arnold M.D.</b>		22b. ADDRESS <b>Lamar, Mo.</b>	
22c. DATE SIGNED <b>6-8-59</b>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>June 8 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>
23d. LOCATION (City, town, or county) <b>Marionville Mo.</b>		23e. LOCATION (State)	
24. FUNERAL DIRECTOR <b>Beeny Funeral Home</b>		ADDRESS <b>Sheldon, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 7 - 59</b>
26. REGISTRAR'S SIGNATURE <b>Marie Kenast</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
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.

146

1961 JUN 2 1961

1961 JUN 2 1961

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 *L. Bernard Buemy*

Licensed Embalmer No. *4761*

P. O. Address... *Sheldon 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.