

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021052

FILED JUN 30 1959

Registration District No. 128 Primary Registration District No. 2000 STATE FILE NUMBER  
Registrar's No. 676

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hosp D.O.A.</b>			Length of stay in 1b <b>25 years</b>		d. STREET ADDRESS (If outside, give location) <b>1252 S. Ferguson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>WOOD</b> Last <b>WOOD</b>				4. DATE OF DEATH Month <b>June</b> Day <b>21</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>August 16, 1913</b>		9. AGE (In years last birthday) <b>45</b> 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) <b>Owner-Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tire exchange</b>		11. BIRTHPLACE (City and state or country) <b>Plano, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Lee Harold Wood</b>			13b. MOTHER'S MAIDEN NAME <b>Nellie (unknown)</b>			14. NAME OF HUSBAND OR WIFE <b>Alma 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>Unknown</b>		17. INFORMANT Address <b>Mrs Alma Wood, Springfield, 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>Acute Circulatory Failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Myocardial Infarction &amp; Coronary Thrombosis</b>							
		DUE TO (c) <b>Atherosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							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. Month, Day, Year _____									
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>1956</b> to <b>1959</b> and last saw <sup>her</sup> him alive on <b>June 18/59</b> Death occurred at <b>7:45 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>[Signature]</b> (Print name and title)			22b. ADDRESS <b>432 E. Commercial, Springfield, Mo.</b>			22c. DATE SIGNED <b>6/24/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<b>Burial</b>		<b>June 24, 1959</b>		<b>White Chapel</b>		<b>Springfield, Mo.</b>			
24. FUNERAL DIRECTOR <b>Jewell E. Wendle</b> ADDRESS <b>Springfield, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>6-24-1959</b>		26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>				

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
R.W. Reid, D.O.

JUL 3 0 1955

JUL 6 1955

JUL 1 0 1959

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 *Bernard F. Wright*

Licensed Embalmer No. *4293*

P. O. Address *Springfield*

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.