

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1959

59-029851

Registration District No. 227 Primary Registration District No. 4339 Registrar's No. 28

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PARIS</u>			Length of stay in 1b <u>75 YRS</u>		c. CITY OR TOWN <u>PARIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HILL ST.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>206 HILL ST.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOE</u> Middle _____ Last <u>WOOD</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>9</u> Year <u>1959</u>				
5. SEX <u>M</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>7/20/1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u>		IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>BUSINESS HOUSE & CHURCH</u>		11. BIRTHPLACE (City and state or country) <u>MONROE Co MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ALFRED WOOD</u>			13b. MOTHER'S MAIDEN NAME <u>NAN HEATHMAN</u>		14. NAME OF HUSBAND OR WIFE <u>ANNA MAE WOOD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>492-24-0986</u>		17. INFORMANT <u>MRS JOE WOOD PARIS, MO.</u> Address _____				
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>Hypernephroma of left Kidney</u>							INTERVAL BETWEEN ONSET AND DEATH <u>N.K.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>10-21-58</u> to <u>8-9-59</u> and last saw him alive on <u>8-9-59</u> Death occurred at <u>10:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>F.A. Barnett, M.D.</u>				22b. ADDRESS <u>PARIS, MO.</u>		22c. DATE SIGNED <u>8-11-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8/11/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WAL. GROVE CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u>			
24. FUNERAL DIRECTOR <u>E.H. AGNEW</u> ADDRESS <u>PARIS, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>8-11-59</u>		26. REGISTRAR'S SIGNATURE <u>F.A. Barnett M.D.</u>			

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. P. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, T.

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.