

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959

59-031581

DED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 935 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA St. Joseph's Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> c. CITY OR TOWN <u>St. Joseph</u> 'Inside Limits' Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>615 1/2 Mary Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Thomas</u> Middle <u>M.</u> Last <u>Woods</u>			<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>13</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 28, 1911</u>	<b>9. AGE (last birthday)</b> <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Auto Salvage</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Spokane, Washington</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Benjamin Franklin Woods</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Clissia Miller</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Gloria Woods</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW #2</u>			<b>16. SOCIAL SECURITY NO.</b> <u>500-07-1375</u>		<b>17. INFORMANT</b> Address <u>Mrs. Gloria Woods St. Joseph, Mo.</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Causes - Unattended Death</u> DUE TO (b) <u>Investigated City Health Dept</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____			
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____</b> Death occurred at <u>9:01 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>City Health Officer</u> <u>Robert W. Kieber MD</u>				<b>22b. ADDRESS</b> <u>St. Joseph, Mo</u>		<b>22c. DATE SIGNED</b> <u>9-15-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>Sept. 16, 1959</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Auburn Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Joseph, Missouri.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Meierhoffer Fleeman, Inc.</u> Address <u>St. Joseph, Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>Sept. 17, 1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. Clark Woodell</u>		

DOCUMENT

MEDICAL CERTIFICATION  
P.W. Kieber, M.D.

BY AFFIDAVIT OF

SEP 29 1959

STATEMENT BY LICENSED EMBALMER

JAN 21 1960

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 Edward E. Harrington

Licensed Embalmer No. 9258

P. O. Address H. J. J. J.

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.