

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 9 1959

59-031629

Registration District 27379-43 REG. NO. 1-30 District No. 3007 Registrar's No. 468

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BUTLER</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>3 YEARS</b>		c. CITY OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>509 PARK AVENUE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLARD</b> Middle <b>(NONE)</b> Last <b>WOODWARD</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>28</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"/> <b>Sept'd. 1923</b>		8. DATE OF BIRTH <b>3-14-91</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CABINET MAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CABINET MAKING</b>	11. BIRTHPLACE (City and state or country) <b>PERRY COUNTY, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>IRA WOODWARD</b>			13b. MOTHER'S MAIDEN NAME <b>ADA CRAIN</b>		14. NAME OF HUSBAND OR WIFE <b>UNKNOWN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, 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>PULMONARY EDEMA, ACUTE, BILATERAL.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>PULMONARY EMPHYSEMA, CHRONIC, BILATERAL.</b>						<b>Unknown</b>	
DUE TO (c) <b>ARTERIOSCLEROSIS, CHRONIC.</b>						<b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. CHOLELITHIASIS, CHRONIC. 2. CYSTITIS, CHRONIC.</b>						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 checked="" type="checkbox"/> NO <input type="checkbox"/> <b>Yes</b>	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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>VA</b>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. <input checked="" type="checkbox"/> attended the deceased from <b>August 15, 1959</b> to <b>Sept. 28, 1959</b> and last saw him <b>her</b> on _____ Death occurred at <b>6:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>J. LESTER HARWELL, M.D., Actg. Pathologist</b> (Degree or title) <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>				22b. ADDRESS		22c. DATE SIGNED <b>9/28/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-1-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cem. Vet. Plot</b>		23d. LOCATION (City, town, or county) <b>Poplar bluff, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Frank-Cotrell Poplar Bluff, Mo.</b>				25. DATE REC'D. BY LOCAL REG. <b>10/3/59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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 Edgar W. Tufford

Licensed Embalmer No. 3394  
P. O. Address Waples 136

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.