

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037137

FILED VS OCT 28 1959

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 196

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Shelby</u> b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rolla</u> Length of stay in 1b OR TOWN <u>4 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shelby P. Mem. Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u> c. CITY OR TOWN <u>Cuba</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>NONE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ARTHUR</u> Last <u>WOOD</u>				4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1959</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>October 28, 1884</u>		9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>13</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>Painting Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>				11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.B.</u>			
13a. FATHER'S NAME <u>John A. Wood, Sr.</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Lawson</u>				14. NAME OF HUSBAND OR WIFE <u>William Ann</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>YES</u>				17. INFORMANT <u>Herman Wood</u> Address <u>Cuba, Mo.</u>							
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>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>					
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.		Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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 <u>1947</u> to <u>Oct 11, 1959</u> and last saw ^{her} him alive on <u>Oct 11, 1959</u> Death occurred _____ P.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>Frank A. Elders, M.D.</u> (Degree or title)						22b. ADDRESS <u>Cuba, Mo.</u>			22c. DATE SIGNED <u>10-12-59</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Oct. 14, 1959</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Kinder Cemetery</u>			23d. LOCATION (City, town, or county) <u>Cuba, Missouri</u> (State)						
24. FUNERAL DIRECTOR <u>RPO, J. H. [Signature]</u> ADDRESS <u>Cuba, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Oct. 13, 1959</u>				26. REGISTRAR'S SIGNATURE <u>Nadine L. Stoll</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6561 8 2 100 SA

STATEMENT BY LICENSED EMBALMER

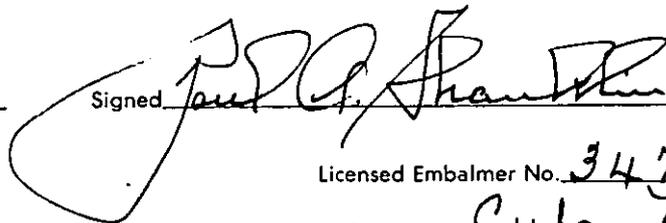
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3472

P. O. Address Cuba, 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.