

**ORIGINAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038637**

**FILED VS NOV 12 1959**

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 2075 Registrar's No. 100

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Stoddard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>							
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Dexter</b>		Length of stay in 1b <b>3 years</b>		c. CITY OR TOWN <b>Dexter</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>128 First Street</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>128 First Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Etharedge</b> Middle <b>NMI</b> Last <b>Woods</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>23</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>6-16-83</b>		9. AGE (last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			11. BIRTHPLACE (City and state or country) <b>Bell City, Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John Woods</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>Bertha Woods</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>430-36-6198</b>		17. INFORMANT <b>Bertha Woods</b> Address <b>Dexter, 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>Cerebral vascular accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b> <b>years</b>			
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>Oct 19<sup>th</sup> 1959</b> to <b>October 23<sup>rd</sup></b> and last saw her/him alive on <b>October 23<sup>rd</sup></b> Death occurred at <b>2.10 P M</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <b>R. Comeau</b> (Degree or title)				22b. ADDRESS <b>Dexter Mo.</b>				22c. DATE SIGNED <b>10/20/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>10-25-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lula Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Senath, Mo.</b>			
24. FUNERAL DIRECTOR <b>Watkins &amp; Sons</b> ADDRESS <b>Dexter, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>11-4-59</b>		26. REGISTRAR'S SIGNATURE <b>Delma J. Jensen</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

**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 Mansel Winters

Licensed Embalmer No. 4717

P. O. Address Dexter Ave

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.

10-1-41

10-1-41