

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031363

FILED VS AUG 17 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 319

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in 1b	c. CITY OR TOWN <u>Hannibal</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>Levering Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>801 Bird Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>STEWART</u> Middle <u>R;</u> Last <u>WOODS</u>			4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/15/1915</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>18</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>Machinist Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>White Star Laundry</u>		11. BIRTHPLACE (City and state or country) <u>Hannibal Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>J. Matt Woods</u>		13b. MOTHER'S MAIDEN NAME <u>Eva May Hedden</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. Matt Woods Sr.</u> Address <u>Hannibal Missouri</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>Coronary occlusion, anterior</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____ 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 <u>Hannibal</u> COUNTY <u>Missouri</u> STATE <u>Missouri</u>
21. I attended the deceased from <u>7/30/60</u> to <u>8/3/60</u> and last saw <u>him</u> alive on <u>8/3/60</u> Death occurred at <u>8:10 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>T. G. Fischer M.D.</u> (Degree or title)	22b. ADDRESS <u>2910 St. Marys, Hannibal, Mo.</u>	22c. DATE SIGNED <u>8/5/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/4/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>
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24. FUNERAL DIRECTOR <u>W. Crawford Smith, Hannibal Missouri</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>8/10/60</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lusk by Phillip M. Herman</u>
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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 John S. Han

Licensed Embalmer No. 4540

P. O. Address Manibal Miss

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.