

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036740

FILED VS. OCT 6 1960

318

1003

9441

STATE FILE NUMBER

NDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Missouri</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>38 days</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis - Little Rock Hospitals, Inc.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>835 North Prospect St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Samuel</b> Last <b>Wooden</b>			4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>1960</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>7-9-1896</b>	9. AGE (last birthday) <b>64</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>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Alberta, Canada</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>			
13a. FATHER'S NAME <b>Leonidas U.H. Woodch</b>			13b. MOTHER'S MAIDEN NAME <b>Fannie Simpson</b>			14. NAME OF HUSBAND OR WIFE <b>Florence</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>702-16-2205</b>		17. INFORMANT Address <b>Florence Wooden, Kansas City, 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>Carcinoma of Prostate</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
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			
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		COUNTY		STATE	
21. I attended the deceased from <b>August 19, 1960</b> to <b>September 25, 1960</b> and last saw him alive on <b>Sept. 25, 1960</b> Death occurred at <b>8:35 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>H. Permutation M.D.</b> (Degree or title)				22b. ADDRESS <b>607 N Grove</b>				22c. DATE SIGNED <b>9-26-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-26-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Coffeyville, Kansas.</b>			
24. FUNERAL DIRECTOR <b>Skinner Funeral Home, Coffeyville, Kans.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>SEP 26 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 9 100

**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 Stanley F. Nip

Licensed Embalmer No. 419

P. O. Address St. L.

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.