

FEDERAL BUREAU OF INVESTIGATION  
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041251

FILED VS. NOV 29 1960

STATE FILE NUMBER

Registration District No. 389 Primary Registration District No. 5161 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <u>MO</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>New Bloomfield</u>		Length of stay in 1b <u>8 yrs</u>	c. CITY OR TOWN <u>New Bloomfield</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>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Eugenia Perry Woods</u>			4. DATE OF DEATH Month Day Year <u>Nov 20 1960</u>			
5. SEX <u>Female</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>June 25-93</u>	9. AGE (last birthday) <u>67</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Callaway Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>H. O. BROWN</u>		13b. MOTHER'S MAIDEN NAME <u>Elsie McCarty</u>		14. NAME OF HUSBAND OR WIFE <u>Albert Woods</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>FRANK E. Woods</u>		17. INFORMANT Address <u>New Bloomfield MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>myocardial failure</u>		<u>weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerotic heart disease</u>	<u>years</u>
	DUE TO (c) <u>arteriosclerosis generalised</u>	<u>year</u>
	<u>Diabetes</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>malnutrition</u>		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 Sept. 1960 to Nov 20 1960 and last saw her/him alive on Nov 20 1960  
 Death occurred at 3:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>William A. Colwell</u> (Degree or title)	22b. ADDRESS <u>Jefferson City MO</u>	22c. DATE SIGNED <u>Nov 20 1960</u>
--	---------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 22-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Ceme</u>	23d. LOCATION (City, town or county) <u>Boone County MO</u>
---	------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Claypool Service New Bloomfield</u>	25. DATE RECD. BY LOCAL REG. <u>11/21/60</u>	26. REGISTRAR'S SIGNATURE <u>Edna Clayton</u>
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 16 1962

**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

*Leroy Claypool*

Licensed Embalmer No. 4412

P. O. Address New Blenheim

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.