

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-024876

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 6960

FILED AUG 7 1961

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Nebraska COUNTY Unknown	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 2 days	c. CITY OR TOWN Surprise, Nebraska Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		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 type="checkbox"/>

3. NAME OF DECEASED (Type or print) First PAULINE Middle Kay Last WOOSLEY	4. DATE OF DEATH Month July Day 23 Year 1961
---	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1942	9. AGE (last birthday) 18	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) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) War West, Virginia	12. CITIZEN OF WHAT COUNTRY USA
--	--	---	---

13a. FATHER'S NAME Walter Woosley	13b. MOTHER'S MAIDEN NAME Nellie Howard	14. NAME OF HUSBAND OR WIFE -----
---	---	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Surprise, Frances Woosley, Nebraska
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral contusion Basal Skull Fracture DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

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 checked="" 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.) auto accident
--	--	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 7-21-61
--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) near Cabarr	20f. CITY, TOWN, OR LOCATION Cabarr	COUNTY Texas	STATE nc.
---	--	---	---------------------	------------------

21. I attended the deceased from 7-22-61 to 7-23-61 and last saw him alive on 7-23-61 Death occurred at 10:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE John E. Keagy M.D.	Degree or title	22b. ADDRESS 1636 S. Glenside	22c. DATE SIGNED 7-28-61
---	-----------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/28/1961	23c. NAME OF CEMETERY OR CREMATORY Big Stone Gap Cemetery	23d. LOCATION (City, town, or county) (State) Big Stone Gap, Virginia
---	-------------------------------	---	---

24. FUNERAL DIRECTOR Ralph Thieme, Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 7-31-61	26. REGISTRAR'S SIGNATURE Effie G. Mellers
---	--	--

DATE AMENDED

INSTEAD OF

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Geith Collier

Licensed Embalmer No. 3632

P. O. Address Springfield

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.