

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029063

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 291

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 9 1963

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u> | | c. CITY OR TOWN <u>Miller</u> | |
| Length of stay in 1b <u>1 month</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u> | | d. STREET ADDRESS (If outside, give location) <u>Rt 2 Box 238</u> | |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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|---|-------------------------------|---|--|---|--------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl Ray Hood</u> | | | 4. DATE OF DEATH Month Day Year <u>July 18 1963</u> | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-7-'98</u> | 9. AGE (last birthday) <u>65</u> | IF UNDER 1 YEAR IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - sawmill - teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming - sawmill</u> | | 11. BIRTHPLACE (City and state or country) <u>Miller, Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>James Jackson Wood</u> | | 13b. MOTHER'S MAIDEN NAME <u>Clara Ethel Rosenberg</u> | |
| 14. NAME OF husband WIFE <u>Gladys Wood</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>no</u> | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT <u>San. Records, Mo. State San</u> | | Address <u>Mt. Vernon</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</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) Bronchogenic carcinoma right lung

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) arteriosclerotic heart disease

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | |

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|--|--|---|
| 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 6-17-63 to 7-18-63 and last saw him alive on 7-18-63
Death occurred at 6:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|------------------------------------|---------------------------------|
| 22a. SIGNATURE (Degree or title) <u>J. Lewis Gale, M.D.</u> | 22b. ADDRESS <u>Mt. Vernon Mo.</u> | 22c. DATE SIGNED <u>7-18-63</u> |
|---|------------------------------------|---------------------------------|

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|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7-21-1963</u> | 23c. NAME OF CEMETERY OR CREMATORY? <u>Seymore</u> | 23d. LOCATION (City, town, or county) (State) <u>N.E. of Miller Mo.</u> |
|---|----------------------------|--|---|

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|--|---------------------------|--|---|
| 24. FUNERAL DIRECTOR <u>Morris - Simon</u> | ADDRESS <u>Miller Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Aug. 5, 1963</u> | 26. REGISTRAR'S SIGNATURE <u>Roy Grantham</u> |
|--|---------------------------|--|---|

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59

1 0550

2 0550

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9 162.1

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12 83-0

13 50

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AUG 13 1963

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

L. B. Feiman

Licensed Embalmer No. 3297

P. O. Address Miller Mo.

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.