

FILED SEP 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28637**

BIRTH NO. _____ REG. DIST. NO. 296 PRIMARY REG. DIST. NO. 6019 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Ray</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ray</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Orrick, Mo.</u>		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Orrick, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>0890</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Farm Home</u>					
3. NAME OF DECEASED (Type or Print) <u>Lola</u>		a. (First)	b. (Middle)	c. (Last) <u>Woods</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 5, 54</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 18, 1886</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Rural Orrick, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>W. D. Summers</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Turner</u>		14. NAME OF HUSBAND OR WIFE <u>Claude 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.	17. INFORMANT'S SIGNATURE OR NAME <u>Claude Woods</u> ADDRESS <u>Orrick, Mo.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>2a</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>	ANTECEDENT CAUSES				
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <u>Coronary arteriosclerosis</u>				
	DUE TO (c) <u>Valvular heart disease</u>				
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4214</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 9, 1954</u> , to <u>5 Sept, 1954</u> , that I last saw the deceased alive on <u>9 Sept, 1954</u> , and that death occurred at <u>3:10 a.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>George E. Sanders M.D.</u>			23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>9 Sept 54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 7, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>O'Dell</u>		24d. LOCATION (City, town, or county) (State) <u>7 Miles North of Orrick, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-9-54</u>	REGISTRAR'S SIGNATURE <u>Helen J. Lark</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. W. Good</u>	ADDRESS <u>Orrick, Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed Charles J. Tipton

Licensed Embalmer No. 45-34

P. O. Address Liberty MD.

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 this body is not embalmed, fact should be so stated above.