

FILED JAN 26 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2693

BIRTH NO. _____		REG. DIST. NO. <u>298</u>		PRIMARY REG. DIST. NO. <u>6024</u>		Registrar's No. <u>1</u>	
1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural P.M.</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lawson (Rural)</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1 mile S. Lawson, Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>1 mile S. Lawson, Mo.</u>			
3. NAME OF DECEASED (Type or Print) <u>SALLIE J. WOODS</u>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 8 1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 26, 1866</u>		9. AGE (in years last birthday) <u>87</u>	10. MONTHS <u>0</u>	11. DAYS <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>George Madden</u>		13b. MOTHER'S MAIDEN NAME <u>Dorinda Grace</u>		14. NAME OF HUSBAND OR WIFE <u>Wm J Woods</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. John Taylor, Lawson, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Left Hemiplegia</u>  ANTECEDENT CAUSES <u>Basilar Arteriosclerosis</u> DUE TO (b)  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u>  <u>20 yr</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>334X</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) <u>Lawson Ray Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 1, 1953</u> , to <u>Jan 8, 1953</u> , that I last saw the deceased alive on <u>Jan 8, 1953</u> and that death occurred at <u>12:03 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Arthur E. Buehner M.D.</u>				23b. ADDRESS <u>Lawson Mo</u>		23c. DATE SIGNED <u>1/16/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-9-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Embair Springs Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Jan 21, 1953</u>		REGISTRAR'S SIGNATURE <u>Mrs. Raymond</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Richard Embair Springs Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 Lancee K. Jarman

Licensed Embalmer No. 4589

P. O. Address Embalmer Springs, 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 this body is not embalmed, fact should be so stated above.