

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22160**
5682

FILED JUL 8 1950

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION STATE SANITARIUM		d. STREET ADDRESS (If rural, give location) 5400 ARSENAL ST.	

3. NAME OF DECEASED (Type or Print) a. (First) E. b. (Middle) NINA c. (Last) WOOD			4. DATE OF DEATH (Month) (Day) (Year) June 29 1950
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5. SEX F	6. COLOR OR RACE W	7. NEVER MARRIED, WIDOWED (Specify)	8. DATE OF BIRTH DEC-13-1873	9. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	IF UNDER 4 HRS. Hours	IF UNDER 4 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME WILLIAM WOOD	13b. MOTHER'S MAIDEN NAME MATTIE WRIGHT	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. C. M. M. Abbe	ADDRESS 3209 Eads Av
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 42nd
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22. I hereby certify that I attended the deceased from **5/1/49** to **6-29-1950**, that I last saw the deceased alive on **June 29, 1950**, and that death occurred at **6:10 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Richard Keller M.D.	(Degree or title)	23b. ADDRESS 5400 Arsenal St	23c. DATE SIGNED 6/29/50
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24a. BURIAL, CREMA TION, REMOVAL (Specify)	24b. DATE JUNE 30-50	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE RECD. BY LOCAL HEALTH DEPT. JUN 3 1950	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schner	ADDRESS 3125 Lafayette Av
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AUG 12 1950

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

Joe B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address *St. Louis*

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.