

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36149**
Registrar's No. **8976**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8976			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO.		c. LENGTH OF STAY (in this place) 1 WEEK		c. CITY OR TOWN St. Louis		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1				e. STREET ADDRESS (If rural, give location) Delmar Hotel 5017 Delmar St.		f. _____			
3. NAME OF DECEASED a. (First) OSCAR			b. (Middle) _____			c. (Last) WOOD			
4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1954		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Nov. 29, 1895	
9. AGE (In years less birthday) 58		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Iron Worker		10b. KIND OF BUSINESS OR INDUSTRY Structural Iron		11. BIRTHPLACE (City and State and Foreign Country) East St. Louis, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles Wood			13b. MOTHER'S MAIDEN NAME Ollie Meuden			14. NAME OF HUSBAND OR WIFE Emma Woods 5100 Ewing			
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. 494-10-4537		17. INFORMANT'S SIGNATURE OR NAME Peggy Hall 5100 Ewing Av.				ADDRESS Ill.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH _____	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 002X					
22. I hereby certify that I attended the deceased from Sept. 25, 1954 , to Oct. 1, 1954 , that I last saw the deceased alive on Oct. 1, 1954 , and that death occurred at 8:20 P.m. , from the causes and on the date stated above.									
23a. SIGNATURE Leo Meuden				(Degree or title) _____		23b. ADDRESS 1515 Lafayette Ave.		23c. DATE SIGNED 10-4-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE Oct. 5/1954		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) St. Charles, Mo.		(State) _____	
DATE REC'D BY LOCAL REG. OCT 4 1954		REGISTRAR'S SIGNATURE Carl Smith MD			25. FUNERAL DIRECTOR'S SIGNATURE Bull-Campbell				
					ADDRESS 5165 Delmar				

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

1977, F. 150

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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 *Ray E Campbell*

Licensed Embalmer No. *388*

P. O. Address *St Louis 8*

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.