

FILED NOV 28 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39943

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10170**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Maac</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Metropolis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>			Length of stay in hospital <b>3 Wks</b>	120 STREET ADDRESS <b>Star Route</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				First <b>Mae</b>	Middle <b>B.</b>	Last <b>Woods</b>	4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 16, 1900</b>		9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Lady</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Good Luck Glove Co.</b>		11. BIRTHPLACE (City and state or country) <b>Union County, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Will Hubbs</b>				14. MOTHER'S MAIDEN NAME <b>Annie Johnson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <b>No. Nil.</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Charles W. Woods, Metropolis, Illinois</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor, verified, glioblastoma multiforme</b> DUE TO (b) <b>Pneumonia, bronchial, lobar</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 weeks</b> <b>1 week</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			193 x					
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 _____ a. m. _____ p. m. _____								
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 <b>10-19-56</b> to <b>Nov. 5, 1956</b> and last saw <b>her</b> alive on <b>Nov 5, 1956</b> Death occurred at <b>4:00</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>George E. Rouelhae M.D.</b>				22b. ADDRESS <b>3720 Washington</b>		22c. DATE SIGNED <b>Nov 5, 1956</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-5-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hall Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Union County, Illinois.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington,</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 7 1956</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

300  
1-56Health,  
Welfare  
Public  
Service

**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.....  
Licensed Embalmer No. ....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.