THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1957

STATE FILE NUMBER 3194

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 509

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1. — Length of stay in 1b
25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN ST.LOUIS — Inside Limits Yes X No ☐
d. STREET ADDRESS 2809 Henrietta. (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First HENRY Middle I. Last WOOD

4. DATE OF DEATH Month Day Year JAN. 14, 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH 7-11=1885
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and state or country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Vincent Wood
14. MOTHER'S MAIDEN NAME Sarah Kemp

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 Address Lillian Friedrich, 2809 Henrietta

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 331X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1/7/57, to 1/14/57 and last saw her/him alive on 1/14/57
Death occurred at 7:36 A.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thos. C. Roach M.D.
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 1/15/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1-17-1957
23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette
25. DATE RECD. BY LOCAL REG. JAN 17 '57
26. REGISTRAR'S SIGNATURE J. Earl Smith, MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in [illegible] diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed H. G. Farris

Licensed Embalmer No. 33

P. O. Address St. Louis

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