

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42812

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11344

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY OR TOWN <u>St. Louis</u>	c. LENGTH OF STAY (In this place township) <u>2mo 21dy</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>26 St. Louis Chronic Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>25705 N. 9th St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) c. (Last) <u>Woodward</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 20, 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>4-9-84</u>
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) / <u>Metropolis, Ill</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>unk.</u>	13b. MOTHER'S MAIDEN NAME <u>unk.</u>	14. NAME OF HUSBAND OR WIFE <u>Nellie Reed (Dec. 1932)</u>
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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) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>319-14-0586a</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records</u>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>RT. Lower Lobar Pneumonia</u>		<u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>490x</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Heart Disease</u>			<u>3 mo</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY / YES <input checked="" type="checkbox"/> NO <input 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?
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22. I hereby certify that I attended the deceased from August 30, 1957, to November 20, 1957, that I last saw the deceased alive on November 20, 1957, and that death occurred at 7:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>	23b. ADDRESS <u>5800 Arsenal</u>	23c. DATE SIGNED <u>11/22/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	24b. DATE <u>11-27-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Crematory</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>NOV 26 57</u>	REGISTRAR'S SIGNATURE <u>Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank O'Donnell</u>	ADDRESS <u>5600 Arsenal St.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

MAY 16 1958

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..

NOT EMBALMED CREMATED BY CITY.

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**. (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.