

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015996
STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 3922

300

1-57

15

684

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 (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEWISH HOSPITAL</u>		Length of stay in 1b <u>35 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>1430th SALISBURY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MELISSA ANN WOOD</u>			4. DATE OF DEATH Month Day Year <u>APRIL 20 1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1959</u>	9. AGE (In years last birthday) FUNDER 1 YEAR Months Days Hours Min. <u>1 5</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NIL</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>RICHARD WOOD</u>		13b. MOTHER'S MAIDEN NAME <u>MARIE NICARD</u>		14. NAME OF HUSBAND OR WIFE <u>NIL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>RICHARD WOOD 1430A SALISBURY</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute gastro-enteritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4/7/59 - 4/20/59</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>571.0</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prematurity prematurity</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 <u>3-15-59</u> to <u>4-20-59</u> and last saw her/him alive on <u>4-20-59</u> Death occurred at <u>3 P.M.</u> <u>3 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Bernard Schwarz</u> (Name or title) <u>Bernard Schwarz, M.D.</u>			22b. ADDRESS <u>4652 Maryland</u> <u>4652 Maryland (8)</u>		22c. DATE SIGNED <u>4-21-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 20 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>		23d. LOCATION (City, town, or country) (State) <u>ST. LOUIS MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>SUEDMEYER & SONS 3934 N. 20th ST.</u>		25. DATE RECD. BY LOCAL REG. <u>APR 21 '59</u>		26. REGISTRAR'S SIGNATURE <u>Heal Smith, M.D.</u> <u>S.P.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Ralph W. Guedenye

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.