

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 27 1959

59-027775

STATE FILE NUMBER

Registration District No. 379 Primary Registration District No. 4469 Registrar's No. 45

DEED

1. PLACE OF DEATH a. COUNTY <u>Sto Genevieve</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sto. Genevieve</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sto Genevieve</u>		Length of stay in lb <u>40 yrs</u>		c. CITY OR TOWN <u>Sto. Genevieve</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sto. Genevieve</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Sto. Genevieve</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Jewell</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 9, 1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lincoln City, Ind</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>		
13a. FATHER'S NAME <u>Joseph Main</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Hedberg</u>			14. NAME OF HUSBAND OR WIFE <u>Hugh F. Wood</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>489-32-8439A</u>		17. INFORMANT <u>Mrs Hazel Wilson</u>			Address <u>Sto. Gen, Mo</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>Coronary Embolism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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. Month, Day, Year _____			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 <u>Jan 2 1959</u> to <u>July 19 1959</u> and last saw her alive on <u>July 19 1959</u> Death occurred at <u>2:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Arthur E. Sawyer M.D.</u> (Degree or title)				22b. ADDRESS <u>Sto. Genevieve Mo</u>			22c. DATE SIGNED <u>7-20-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BOR 141</u>		23b. DATE <u>7-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crestlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Sto. Genevieve, Mo</u>				
24. FUNERAL DIRECTOR <u>Genevieve Stanton Co, Mo</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>7/21/1959</u>		26. REGISTRAR'S SIGNATURE <u>Frank G. Baker</u>				

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James H. Smith*

Licensed Embalmer No. 3817

P. O. Address St. Louis, Mo.

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