

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS NOV 16 1959

59-042740

2 9401

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 days	c. CITY OR TOWN Maplewood Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7262 Zephyr Pl. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Agnes Middle C. Last Wood	4. DATE OF DEATH Month 10 Day 12 Year 59
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/17/94	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressfitter - Ret.	10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	11. BIRTHPLACE (City and state or country) Potosi, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Chesterfield Payne	13b. MOTHER'S MAIDEN NAME Mollie Cole	14. NAME OF HUSBAND OR WIFE Everett N. Wood
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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) No	16. SOCIAL SECURITY NO. 489-14-3192	17. INFORMANT Mr. Everett N. Wood, 7262 Zephyr	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 10 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Adeno Carcinoma, Breast	
	DUE TO (c) 170X	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ Minute _____ 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
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21. I attended the deceased from Jan 16, 1950 to Oct 12, 1959 and last saw her alive on 10/12/59 Death occurred at St Louis 11:30 A m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Norman D. Bray M.D. (degree or title)	22b. ADDRESS 634 N. Deane	22c. DATE SIGNED 10/13/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 10/15/59	23c. NAME OF CEMETERY OR CREMATORY Twin Cemetery	23d. LOCATION (City, town, or county) Caledonia Mo.
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24. FUNERAL DIRECTOR Drehmann-Harral	ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. OCT 13 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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SENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

634 N. Grand
01. 2-3868

Hrs. 1-3 Tues.

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 Warren A. Carver

Licensed Embalmer No. 3534

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.