SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

61-007048
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1264

FILED VS FEB 20 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b: 33 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois
b. COUNTY: Madison
c. CITY OR TOWN: East Alton
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 106 Main
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Clarence Middle: E. Last: Wood
4. DATE OF DEATH: Month: February Day: 5 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 12/13/1881
9. AGE (last birthday): 79
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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Raymond,Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: William T.Wood
13b. MOTHER'S MAIDEN NAME: Laura E.Warner
14. NAME OF HUSBAND OR WIFE: Mary
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Verna E.Bosomworth Address: Shipman,Illinois

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) PULMONARY EMBOLISM — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) THROMBOSIS OF LEG VEINS
DUE TO (c) 466+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): REPAIR OF HIATUS HERNIA 19 DAYS BEFORE DEATH
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 14 Jan 1961, to 5 Feb 1961 and last saw him/her alive on 4 Feb 1961
Death occurred at 9:00 a.m. 5 Feb 1961 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Andrew McCance, MD
22b. ADDRESS: 216 S. Kingshighway St Louis, Mo
22c. DATE SIGNED: 7 Feb 61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2/8/61
23c. NAME OF CEMETERY OR CREMATORY: Wood Cemetery
23d. LOCATION (City, town, or county) (State): Macoupin,Ill.
24. FUNERAL DIRECTOR ADDRESS: Jacoby-Wise, Bunker Hill,Ill.
25. DATE RECD. BY LOCAL REG.: FEB 7 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | DOCUMENT | 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Not Embalmed

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.