

OUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-012189

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 684 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Va.</b> b. COUNTY <b>Mercer</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Clayton</b>		c. CITY OR TOWN <b>Princeton, W. Va.</b>	
Length of stay in 1b <b>DOA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>Maple Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ELBERT</b> Middle <b>CLINTON</b> Last <b>WOOD</b>			4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1961</b>		
---	--	--	---	--	--

5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/1891</b>	9. AGE (last birthday) <b>70</b>	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) <b>Miner and Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mining-Farming</b>	11. BIRTHPLACE (City and state or country) <b>Goodwill, West Va.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	--	---	---

13a. FATHER'S NAME <b>Ruben Wood</b>	13b. MOTHER'S MAIDEN NAME <b>Doshia Wood</b>	14. NAME OF HUSBAND OR WIFE <b>Dora Wood</b>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Dora Wood</b> Address <b>Maple Ave. Princeton, W. Va.</b>
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown Natural Causes</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
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 checked="" type="checkbox"/> NO <input 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 \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **11:09P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John C. Murphy MD Asst. Health Commissioner</b>	22b. ADDRESS <b>801 S. Brentwood Clayton, Mo.</b>	22c. DATE SIGNED <b>3/20/61</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Rail</b>	23b. DATE <b>3/11/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven, Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Princeton, West Virginia</b>
--	-------------------------------	--	--

24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>3-11-61</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy MD</b>
---	--	---

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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.