MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

PARTMENT OF PUBLIC HEALTH AND WELFARE

-62-003429
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 140

FILED JAN 11 1962

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Length of stay in 1b: 2 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ILL. b. COUNTY: ST. CLAIR
c. CITY OR TOWN: JERSEYVILLE — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 404 E. Pearl St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ELMER Middle Last ATWOOD
4. DATE OF DEATH: Month JANUARY Day 4 Year 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 6/20/1879
9. AGE (last birthday): 82 — 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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: COMMON
11. BIRTHPLACE (City and state or country): GREEN CO. ILL.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: JOSEPH ATWOOD
13b. MOTHER'S MAIDEN NAME: DUNHAM
14. NAME OF HUSBAND OR WIFE: CARRIE ATWOOD (deceased)

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.:
17. INFORMANT: Pearl Scher — Address: 4516 Pope Ave. St. Louis Mo.

18. CAUSE OF DEATH (Enter only one cause per line fo
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): THROMBOSIS OF SUPERIOR MESENTERIC ARTERY — INTERVAL BETWEEN ONSET AND DEATH: 48 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROSIS — 5/ YEARS
DUE TO (c): 450.0

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. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION

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 JAN. 2, 1962, to JAN. 4, 1962 and last saw her/him alive on JANUARY 4, 1962
Death occurred at 3:45 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. O. Vermillion, M.D. M.D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 1/4/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-6-62
23c. NAME OF CEMETERY OR CREMATORY: Kane Cemetery
23d. LOCATION (City, town, or county) (State): Kane Ill.

24. FUNERAL DIRECTOR: Jacoby Bros. — ADDRESS: Jerseyville, Ill.
25. DATE RECD. BY LOCAL REG.: JAN 5 1962
26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

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 Frank Pronoff

Licensed Embalmer No. 4356

P. O. Address St Louis Mo

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.