

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH: (a) County Saint Louis (b) City or town Jefferson Barracks (c) Name of hospital or institution Veterans Administration Facility (d) Length of stay: In hospital or institution Adm: 4-22-39

2. USUAL RESIDENCE OF DECEASED: (a) State Missouri (b) County -- (c) City or town Saint Louis (d) Street No. 3431 Michigan Avenue (e) If foreign born, how long in U. S. A? -- years.

3. (a) PRINT FULL NAME Thomas H. Wood (b) If veteran, name war Spanish Amer. (c) Social Security No. --

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married (b) Name of husband or wife Mary A. (c) Age of husband or wife if alive -- years 7. Birth date of deceased Sept. 15, 1876

8. AGE: Years 62 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Marshall, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business --

MOTHER FATHER { 12. Name John Wood 13. Birthplace Missouri (City, town, or county) (State or foreign country) 14. Maiden name Jane Lawson 15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature (b) Address Vet. Administration Facility

17. (a) Burial (b) Date thereof Sept. 13, 39r (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery, Co.

18. (a) Signature of funeral director (b) Address 7814 S. Broadway

19. (a) SEP 11 1939 (b) R. Meyer M.D. (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 10 year 1939 hour 8 minute 50 A. M.

21. I hereby certify that I attended the deceased from April 22, 1939, to September 10, 1939, that I last saw him alive on September 10, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate with extensive metastases to ribs and pelvic bones. Duration Unkn.

Due to

Due to 57

Other conditions None (Include pregnancy within 3 months of death)

PHYSICIAN Major findings: Radon seeds implanted Of operations in prostate in 1938 (previous to admission to this hospital) Of autopsy See cause of death Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) (b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature C. W. HUGHES, Chief Med. Officer (M.D. or other) Address Veterans Administ. Fac. Date signed 9-11-39

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

*Edwin H. Leisinger*

Licensed Embalmer No: *4849*

P. O. Address: *6464 Chippewa*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**