

NOV 16 1940 791
Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 8298

1. PLACE OF DEATH:

(a) County _____
(b) City or town St Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Flora
(If outside city or town limits, write "RURAL") NR
(d) Street No. 111 E. 4th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 4
year 1940 hour 11 minute P.M.
21. I hereby certify that I attended the deceased from
9-17-40 ~~1940~~ to 10-4- 1940
that I last saw her alive on 10-4- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of the bile duct
= generalized metastasis

Duration

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

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 J. B. Bradley (M. D. or other) _____

Address BARNES HOSPITAL Date signed 10-5-40

3. (a) PRINT FULL NAME Martha Equila Wood

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Wilson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 7 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 5 27 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Holcomb

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wilson Wood

(b) Address Flora, Ill.

17. (a) Removal (b) Date thereof 10-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flora, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) OCT 5 1940 (b) J. B. Bradley
(Date received local registrar) (Signature)

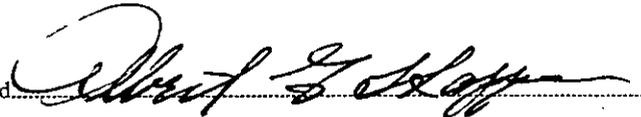
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No..... 2971

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