

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **7014**
Registrar's No. **1178**

BIRTH NO. **FILED MAR 4 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY			
b. CITY OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (If this place) 15 YRS		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1211 1/2 So BROADWAY		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 99			
e. STREET ADDRESS (If rural, give location) 1211 1/2 So BROADWAY		• STREET ADDRESS (If rural, give location) 2070			
3. NAME OF DECEASED (Type or Print) a. (First) MARTHA b. (Middle) M c. (Last) WOOD		4. DATE OF DEATH (Month) (Day) (Year) Feb 6 1954			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	
8. DATE OF BIRTH Dec 18, 1864		9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months Days 89	
11. BIRTHPLACE (City and State or Foreign Country) STODDARD COUNTY MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME JAMES CAMPBELL		13b. MOTHER'S MAIDEN NAME Polly COOPER		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME H.H. KIRCHER	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-Pneumonia Pulmonal ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Thrombosis DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 332X	
22. I hereby certify that I attended the deceased from Jan 1952 to Feb 6, 1954, that I last saw the deceased alive on Feb 5, 1954, and that death occurred at 5:03 P.M., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Joseph B. Carney MD		23b. ADDRESS 906 Olive		23c. DATE SIGNED 2-6-54	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 2/8/54		24c. NAME OF CEMETERY OR CREMATORY 100F CEMETERY	
24d. LOCATION (City, town, or county) (State) CHARLESTON, MO		25. FUNERAL DIRECTOR'S SIGNATURE Red Fendler			
DATE REC'D BY LOCAL REG. FEB 6 1954		REGISTRAR'S SIGNATURE Earl Smith MD		ADDRESS 7420 Michigan	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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 *W. G. Peterson*.....

Licensed Embalmer No. *376*.....

P. O. Address *7420 M*.....

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.