

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14370**

FILED MAY 12 1954

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>541</u>		Registrar's No. <u>1054</u>	
1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <b>MISSOURI.</b> b. COUNTY <b>ST. LOUIS.</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CLAYTON,</b>		c. LENGTH OF STAY (in this place) <b>8 Months</b>		c. CITY OR TOWN <b>CLAYTON,</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>#506 OLD BONHOMME ROAD,</b>				e. STREET ADDRESS (If rural, give location) <b>#506 OLD BONHOMME RD.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>CECYL</b> b. (Middle) <b>G.</b> c. (Last) <b>WOOLDRIDGE.</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 4th, 1954</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Feb. 8, 1885</b>	
9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Trigg County, Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>John J. Gaines.</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Hill</b>		14. NAME OF HUSBAND OR WIFE <b>Major Wooldridge.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Clyde B. Smith, 506 Old Bonhomme Rd.</b>			
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) <b>Carcinoma of Stomach</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year ?</b>	
19a. DATE OF OPERATION <b>1953</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Stomach (Inoperable)</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>151X</b>			
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? _____			
22. I hereby certify that I attended the deceased from <b>January 13, 1954</b> , to <b>May 4, 1954</b> , that I last saw the deceased alive on <b>May 3, 1954</b> , and that death occurred at <b>10:45 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Clyde B. Smith M.D.</b>				23b. ADDRESS <b>3720 Washington</b>		23c. DATE SIGNED <b>5-4-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>5/5/1954</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>Hopkinsville, Kentucky.</b>	
DATE REC'D BY LOCAL REG. <b>5/4/54</b>		REGISTRAR'S SIGNATURE <b>Richard R. Sommers</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. R. Lupton &amp; Sons, 7233 Delmar Blv'd.,</b>			

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

JE: 3-6204.  
Res: 8006 Gannon Ave,  
PA: 7-2117.

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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 *Gerald W. Shoene*.....

Licensed Embalmer No. *386*.....

P. O. Address *St. Louis*.....

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.