

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY _____ 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO. b. COUNTY _____b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN City c. LENGTH OF STAY (In this place) 5 yrs 6 mo 28 dys d. CITY OR TOWN City .
c. CITY OR TOWN City . d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital e. STREET ADDRESS (If rural, give location) 13 5800 Arsenal St. 212 9

3. NAME OF DECEASED (Type or Print) a. (First) Martha b. (Middle) J. c. (Last) Wocet 4. DATE OF DEATH (Month) (Day) (Year) 7- 8- 1954

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH Dec. 30, 1871 9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (City and State or Foreign Country) Illinois. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Edward Allen 13b. MOTHER'S MAIDEN NAME Jane Gartside 14. NAME OF HUSBAND OR WIFE William

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. none 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Billie H. Wocet 210 Hereford St.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease. INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
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.19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT (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) m. 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 4200

22. I hereby certify that I attended the deceased from 1-6-____, 19 49, to 7-8-____, 19 54, that I last saw the deceased alive on 7-8-____, 19 54, and that death occurred at 2:02a. m., from the causes and on the date stated above.

22a. SIGNATURE Palmer Pruesen Bowditch M.D. (Degree or title) 22b. ADDRESS 5800 Arsenal St. 22c. DATE SIGNED 7-8-54

24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE 7-9-54 24c. NAME OF CEMETERY OR CREMATORY Church Cemetery 24d. LOCATION (City, town, or county) (State) Shiloh, Ill.

DATE REC'D BY LOCAL REG. JUL 8 1954 REGISTRAR'S SIGNATURE J. Carl Smith M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alexander & Sons 6175 Delmas Blvd (Licensed Embalmer's Statement on Reverse Side)

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

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 *Jos. E. M. McCulloch*

Licensed Embalmer No. *24*

P. O. Address *6175 D*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.