

No. 300  
10. 48

FILED AUG 23 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29461**  
Registrar's No. **1996**

XC-3 112 029  
REG. #117878

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **717** PRIMARY REG. DIST. NO. **500**

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>BUCHANAN</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>JEFFERSON BARRACIS, MO.</b>		c. LENGTH OF STAY (in this place) <b>12 DAYS</b>	c. CITY OR TOWN <b>ST. JOSEPH</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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>924 1/2 N. 19th STREET</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>VERNON</b> b. (Middle) <b>D.</b> c. (Last) <b>WOOD</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>8-16-54</b>
---	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-16-89</b>	9. AGE (In years last birthday) <b>64 YEARS</b>	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) <b>HOSPITAL ATTENDANT</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>STATE HOSPITAL</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>ELGIN, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	---	---	---

13a. FATHER'S NAME <b>JOHN WOOD</b>	13b. MOTHER'S MAIDEN NAME <b>NINA DAVIS</b>	14. NAME OF HUSBAND OR WIFE <b>DAISY WOOD</b>
-------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>	16. SOCIAL SECURITY NO. <b>474 03 3090</b>	17. INFORMANT'S SIGNATURE OR NAME <b>VA HOSPITAL RECORDS, JEFF. BRKS., MO.</b>	ADDRESS
--	--	--	---------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL HEMORRHAGE DUE TO HYPERTENSION</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 <b>CHRONIC BRAIN SYNDROME WITH CEREBRAL ARTERIOSCLEROSIS &amp; PSYCHOTIC REACTION</b> Conditions contributing to the death but not related to the disease or condition causing death		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION (TUBERCULOSIS, PULMONARY, CHRONIC, MODERATELY, PSYCHOTIC, (ADVANCED, ACTIVE, BRONCHOPNEUMONIA, ACUTE) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	19c. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <b>331XA</b>
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **8-4-54**, 19\_\_\_, to **8-16-54**, 19\_\_\_, and that death occurred at **3:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>CM Schels M.D.</b>	23b. ADDRESS <b>VET. ADM. HOSPITAL, JEFF. BRKS., MO.</b>	23c. DATE SIGNED <b>8-16-54</b>
--------------------------------------	--	---------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal train</b>	24b. DATE <b>8-18-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Unk</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. <b>8/17/54</b>	REGISTRAR'S SIGNATURE <b>Heckel R. Lambert</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Southern Funeral Home</b>	ADDRESS <b>322 S. Grand Blvd., St. Louis, Mo.</b>
---	--	---	---

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

500

0117

SEP 11 1951

**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.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

WRITE PLAINLY—USING UNFADING BLACK INK

Enter only one cause per line for (a), (b), and (c)

\*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a)

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  
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  NOT WHILE AT WORK 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 4a m., from the causes and on the date stated above.

23a. SIGNATURE

(Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24b. DATE

7-20-54

24c. NAME OF CEMETERY OR CREMATORY

Resurrection Cem.

24d. LOCATION (City, town, or county) (State)

St. Louis, County, Mo.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

Southern Funeral Home 6322 S. Grand St. Louis, Mo.

ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 *Francis J. Wyland*.....  
Licensed Embalmer No...4512

P. O. Address...63225 Grand

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.