

FILED JAN 6 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

BIRTH NO. .... REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10896**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>10 days</b>		e. STREET ADDRESS (If rural, give location) <b>3728 Winnebago</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1</b>			

3. NAME OF DECEASED (Type or Print) <b>ROSE</b>		a. (First) <b>WOOLDRIDGE</b>		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>DECEMBER 12, 1955</b>	
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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>2-3-1776</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Desloge, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>John Green</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Otis Wooldridge, 2808 Union</b>		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>auricular fibrillation</b>	b. <b>auricular fibrillation</b>			
ANTECEDENT CAUSES	DUE TO (b) <b>arterio sclerotic heart disease</b>			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <b>Broncho pneumonia</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<b>Broncho pneumonia</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>420.0</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)
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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
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22. I hereby certify that I attended the deceased from **12-1-1955** to **12-12-1955**, that I last saw the deceased alive on **12-12-1955**, and that death occurred at **7:45 AM**, from the causes and on the date stated above.

23a. SIGNATURE <b>E Robert Schutt</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>1515n LAFAYETTE AVE.</b>	23c. DATE SIGNED <b>12-12-55.</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12-15-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis co, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>DEC 13 1955</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>McLaughlin F.H., Inc., 2301 Lafayette</b>	ADDRESS
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WRITE PLAINLY—USING UNFAADING 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 *L.R. Casper*

Licensed Embalmer No. *365*

P. O. Address *2319 Poy*

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.