THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6772
STATE FILE NUMBER 932

FILED FEB 25 1957 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hosp #1 — Length of stay in 1b 25 — 2199

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 4103 Olive st. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Everett Middle Last Woods
4. DATE OF DEATH Month Day Year Jan 28, 1957
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-17-1910
9. AGE (In years last birthday) 46 — 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) laborer
10b. KIND OF BUSINESS OR INDUSTRY unknown
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Noah Woods
14. MOTHER'S MAIDEN NAME Addie Vaughan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT Address Ethel Woods, 4104 Olive, Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) gastric ulcer, malignant
DUE TO (c) Hodgkin disease 201X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Purulent peritonitis, Left subphrenic abscess
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Nov 21 1956 A.M. 2:25 a, to Jan 28, 1957 and last saw her/him alive on Jan28, 1957
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leroy F. Ortmeyer M. D.
22b. ADDRESS 1515 Lafayette
22c. DATE SIGNED 1/2 8/57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE 1-28-57
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State) Farmington, Mo.

24. FUNERAL DIRECTOR ADDRESS Cozean, Farmington, Mo.
25. DATE RECD. BY LOCAL REG. JAN 29 '57
26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300 0
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

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. (
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.