

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6774

State File No.

FILED FEB 25 1957

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1288

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

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) ST Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION. 01 2702 nd Madison 209, 2702 nd Madison		e. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Woods c. (Last) Woods		4. DATE OF DEATH (Month) (Day) (Year) Feb 5 1957	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 26, 1892
9. AGE (In years last birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	11. BIRTHPLACE Ark.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Robert Woods	13b. MOTHER'S MAIDEN NAME Salie Thornton	14. NAME OF HUSBAND OR WIFE Mable Woods	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, m. no., or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME Mable Woods 2702 nd Madison 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH Several mos. 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. 422.2	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
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 1-6-1957 to 2-5-1957, that I last saw the deceased alive on 2-4-1957, and that death occurred at 8 P. M., from the causes and on the date stated above.			
23a. SIGNATURE Clyde B. Kane M.D. (Degree or title)		23b. ADDRESS 706 Walton	23c. DATE SIGNED 2-6-57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-9-57	24c. NAME OF CEMETERY OR CREMATORY Pilgrim	24d. LOCATION (City, town, or county) (State) Martanna Arkansas
DATE REC'D BY LOCAL REG. FEB 8 '57	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.	

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.....
8503
F. E. Culkin

Licensed Embalmer No. 4198

P. O. Address.....
Shelby

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.