. Health,
& Welfare
. Public
h Service

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-038357

STATE FILE NUMBER

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10282

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St.Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Enroute City Hospital — Length of stay in 1b 38	d. STREET ADDRESS (If outside, give location) 4557a Delmar — Reside on Farm Yes [ ] No [X] 1990

3. NAME OF DECEASED (Type or print)	First: Nellie	Middle: V.	Last: Wood	4. DATE OF DEATH Month Day Year: October 26, 1958
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: September 25,1893	9. AGE (In years last birthday): 65 — 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): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: At Home	11. BIRTHPLACE (City and state or country): Nashville, Tennessee.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: John Hunt	13b. MOTHER'S MAIDEN NAME: Ellen Adcock	14. NAME OF HUSBAND OR WIFE: Janes R. Wood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) Nil	16. SOCIAL SECURITY NO.: 409-20-1739	17. INFORMANT: James R. Wood, Address: 4557a Delmar Blvd.		

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) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH 1 yr

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 163 x

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 June 58, to Oct 25th 58 and last saw her alive on 10-25-58

Death occurred at 1:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Clyde B Kane M.D.	22b. ADDRESS: 706 Walton St Louis Mo.	22c. DATE SIGNED: 10-27-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 10-28-58	23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri.
24. FUNERAL DIRECTOR: Albert H. Hoppe, ADDRESS: 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG.: OCT 27 '58	26. REGISTRAR'S SIGNATURE: J Earl Smith M.D. GP	

(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 Geo W Wilkinson

Licensed Embalmer No. 3573

P. O. Address St Louis

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.