

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031026

FILED VS AUG 26 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2045 STATE FILE NUMBER

IDED

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|--|---|---|--|---|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights | | Length of stay in hospital 1 day | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 6132 Alaska Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Baby Boy Middle Woodruff Last Woodruff | | | | 4. DATE OF DEATH Month July Day 26 Year '59 | | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 26 July 59 | 9. AGE (last birthday) IF UNDER 1 YEAR: Months 1 Days 30 IF UNDER 24 HR: Hours 1 Min. 30 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo | | 12. CITIZEN OF WHAT COUNTRY USA. | |
| 13a. FATHER'S NAME John D. Woodruff | | | 13b. MOTHER'S MAIDEN NAME Frances Ballard | | | 14. NAME OF HUSBAND OR WIFE ----- | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT John D. Woodruff Address 6132 Alaska Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO (b) Immaturity DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 30 July 59 to 26 July 59 and last saw her/him alive on 26 July 59 Death occurred at 7 AM m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Hubert G. Ritter MD. | | | | 22b. ADDRESS 16 Hampton Village Place St. Louis 9 Mo | | | 22c. DATE SIGNED 7-29-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | | |
| Burial | | July 31 1959 | Memorial Park Cem. | | St. Louis, Mo. | | | |
| 24. FUNERAL DIRECTOR A. H. Bocklage ADDRESS 6536 Clayton Rd. | | | 25. DATE RECD. BY LOCAL REG. 7-31-59 | | 26. REGISTRAR'S SIGNATURE John B. Murphy M.D. | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Not Embalmed
W. H. Brinkley
Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.