

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034518

FILED VS. SEP 22 1959

2 8403

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. Baptist Hosp.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>4451 Labadie Ave.</i>
3. NAME OF DECEASED (Type or print) First <i>ROSA</i> Middle <i>WOODLING</i> Last		4. DATE OF DEATH Month <i>Sept.</i> Day <i>10,</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1/6/1877</i>
9. AGE (last birthday) <i>82</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13a. FATHER'S NAME <i>Bernard Droll</i>	
13b. MOTHER'S MAIDEN NAME <i>Alice Thomas</i>		14. NAME OF HUSBAND OR WIFE <i>Thomas Woodling Dec'd</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mr. B. Woodling</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism, acute</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
DUE TO (b) <i>Mesenteric Artery Thrombosis</i>		<i>2 days.</i>	
DUE TO (c) <i>Arterio Sclerotic Heart Disease,</i>		<i>15 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fractured Rt. Hip - Operated 9-9-59</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>Fell at Halls Terry Nursing home</i>	
20c. TIME OF INJURY Hour <i>7</i> a.m. p.m. Month, Day, Year <i>Sept 3 59</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bridge, etc.) <i>2115 Kappel Dr. St. Louis Co. Mo.</i>		
20e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN OR LOCATION <i>St. Louis Co. Mo.</i>		
21. I attended the deceased from <i>July 14 1948</i> to <i>Sept 10 1959</i> and last saw her <i>Sept 10 1959</i> live on <i>Sept 10 1959</i> . Death occurred at <i>9:45 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>C. Rush McClellan M.D.</i>		22b. ADDRESS <i>906 Olive, St. Louis 1 Mo.</i>	22c. DATE SIGNED <i>9-11-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9/12/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Missouri</i>
24. FUNERAL DIRECTOR <i>JOHN STYGAR &amp; SON</i>		25. DATE RECD. BY LOCAL REG. <i>SEP 11 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *J. M. Ruster*

Licensed Embalmer No. 3980

P. O. Address St. Louis, T.

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.