

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-042869**

FILED **NOV 3 0 1959**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2924

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>DOA</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4339 Lindell</b> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Willard</b> Middle <b>A.</b> Last <b>Wood</b>			4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8/26/1903</b>
9. AGE (last birthday) <b>56</b>		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) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Unknown Wood</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Breiderbach</b>
14. NAME OF HUSBAND OR WIFE <b>Clara</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>197-07-5637</b>
17. INFORMANT <b>Mrs. Dell Ingram, 712 O'Fallon St.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary artery Sclerosis</b> DUE TO (c) <b>4201</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arterial Hypertension</b>			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 Month, Day, Year a.m. p.m.	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 <b>May 1948</b> to <b>Nov 4, '59</b> and last saw <b>him</b> alive on <b>Oct 31, '59</b> Death occurred at <b>1:00 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Clement J. Sullivan M.D.</b>		22b. ADDRESS <b>4161 Lindell</b>	22c. DATE SIGNED <b>11-4-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOCAL</b>	23d. LOCATION (City, town, or county) (State) <b>Augusta, Ill.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>11-4-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis

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.