

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

**-60-004261**

**FILED VS. JAN 29 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 603**

STATE FILE NUMBER \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b _____		c. CITY OR TOWN <b>Sullivan</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>Missouri Baptist Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>316 Division St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>John</b> Last <b>Woodcock</b>				4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2/18/1900</b>		9. AGE (last birthday) <b>59</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <b>Sullivan, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>					
13a. FATHER'S NAME <b>John Woodcock</b>				13b. MOTHER'S MAIDEN NAME <b>Stella Manion</b>				14. NAME OF HUSBAND OR WIFE <b>Stella</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>490-05-6115</b>		17. INFORMANT Address <b>Stella Woodcock, Sullivan, Mo.</b>							
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 failure</b> <b>arteriosclerotic heart disease</b> and <b>cardiac asthma</b> and <b>Coronary Arteriosclerosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>(3)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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.) <b>420.0</b>									
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.) <b>Jan 15, 1960</b>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>J. Chukada M.D.</b>						22b. ADDRESS <b>Medical West Bldg</b>			22c. DATE SIGNED <b>1/18/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-19-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Schmidt Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Strain, Mo.</b>						
24. FUNERAL DIRECTOR ADDRESS <b>Shaffer's Chapel, Sullivan, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 18 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b> <i>m.s.R.</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 \_\_\_\_\_ 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 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.