

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1960

-60-033103

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8301** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Decatur	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR St. Louis Little Rock Hospital, Inc.		d. STREET ADDRESS (If outside, give location) 2341 East Prairie Ave.	

3. NAME OF DECEASED (Type or print) First WILLIAM Middle LOUIS Last WOODS			4. DATE OF DEATH Month August Day 22 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1900	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Chicago, Illinois	
13a. FATHER'S NAME William Woods		13b. MOTHER'S MAIDEN NAME Hilda Nelson		14. NAME OF HUSBAND OR WIFE Dorothy Woods	

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. 329-01-1314	17. INFORMANT Address Mrs. Dorothy Woods, 2341 East Prairie Decatur, Ill.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cachehia		
DUE TO (b) Terminal ca Prostate		
DUE TO (c) Generalized Metastasis		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 177X
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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
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21. I attended the deceased from July 23-1960 to August 22, 1960 and last saw him alive on Aug. 22- 1960	
Death occurred at 12:00 noon m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <i>W. J. Moran</i>	22b. ADDRESS 1755 South Grand Ave.	22c. DATE SIGNED 8-23-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-23-1960	23c. NAME OF CEMETERY OR CREMATORY Macon County Memorial Cem.	23d. LOCATION (City, town, or county) (State) Harristown, Illinois
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24. FUNERAL DIRECTOR J.J. Moran Funeral Home Decatur, Ill.	25. DATE RECD. BY LOCAL REG. AUG. 23, 1960	26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.D.</i>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.