

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

**-60-036878**

FILED VS. OCT 10 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2783

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in lb <u>8 weeks</u>	c. CITY OR TOWN <u>Clayton</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>35 Topton Way</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>35 Topton Way</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>LEE</u> Last <u>WOOD</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1960</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1930</u>	9. AGE (last birthday) <u>30</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	11. BIRTHPLACE (City and state or country) <u>Mammoth Springs, Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Ned R. Wood</u>	13b. MOTHER'S MAIDEN NAME <u>Ruth Mullins</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>487-32-0176</u>	17. INFORMANT <u>Clayton</u> Address <u>Missouri</u> <u>Ned R. Wood-35 Topton Way</u>
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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: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>? CARCINOMA OF THE Ovary</u>	
	DUE TO (c) <u>-</u>	

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"/> N- <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 <u>Clayton</u>	COUNTY <u>St. Louis</u>	STATE <u>Missouri</u>
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21. I attended the deceased from 6/7/60 to 9/16/60 and last saw her alive on 9/16/60  
Death occurred at 5:15 PM P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John M. Taylor M.D.</u>	22b. ADDRESS <u>114 N. Taylor Ave St. Louis Mo.</u>	22c. DATE SIGNED <u>9/19/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-17-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MAMMOTH SPRINGS ARKANSAS</u>
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24. FUNERAL DIRECTOR <u>Carter Funeral Home-West Plains Mo.</u>	ADDRESS <u>West Plains Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-20-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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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 Richard J. Van Jr.

Licensed Embalmer No. 4800

P. O. Address Rickwood

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.