URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1960

-60-040398

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10395

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b: 3 weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: Jefferson
c. CITY OR TOWN: Mount Vernon
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 9421½ Salem Rd.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: LOUISE Middle: NMN Last: WOOD
4. DATE OF DEATH: Month: OCTOBER Day: 24 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 12/10/1895
9. AGE (last birthday): 64
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): Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Mount Vernon, Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Bert Warren
13b. MOTHER'S MAIDEN NAME: Della Wilker
14. NAME OF HUSBAND OR WIFE: John S. Wood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: John W. Wood, Address: Rolla, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus. — INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Thrombosis of Right Carotid Artery — 2 weeks
DUE TO (c): 332 X
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. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PEREORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10/6/60 to 10/24/60 and last saw her/him alive on 10/24/60
Death occurred at 11:46 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): F.R. Bradley M.D. F.R. Bradley, M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 10/25/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-27-60
23c. NAME OF CEMETERY OR CREMATORY: Olio Twp. Cemetery
23d. LOCATION (City, town, or county) (State): Eureka, Ill.
24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, Inc., 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: OCT 26 1960
26. REGISTRAR'S SIGNATURE: Neal Smith, M.D.

DOCUMENT

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. 4108

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.