

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN Jerseyville	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) Leavitt St.	

3. NAME OF DECEASED (Type or print)	First HARVEY	Middle W.	Last WOOLARD	4. DATE OF DEATH	Month DECEMBER	Day 28	Year 1960
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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 2-25-1895	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Custodian	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Saline Co., Ill.	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Joe Woolard	13b. MOTHER'S MAIDEN NAME Betty Corn <del>XXXXXX</del>	14. NAME OF HUSBAND OR WIFE Amelia Woolard
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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) Yes	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Amelia Woolard, Jerseyville, 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) Acute Myocardial Infarction		1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Recurrent Pneumonitis - etiology unknown	few months
	DUE TO (c) 492X	

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 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 COUNTY STATE
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21. I attended the deceased from 10/4/60 to 12/28/60 and last saw him <sup>8:39 a.m.</sup> live on 12/28/60.  
Death occurred at 8:39 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C.O. Vermillion, M.D.</i> C.O. Vermillion, M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 12/28/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-28-60	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) Jerseyville, Ill.
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. DEC 28 1960	26. REGISTRAR'S SIGNATURE <i>Leon 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 Etton R. Remel

Licensed Embalmer No. 428

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.