

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047032

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12256

AMENDED

FILED JAN 11 1962

1. PLACE OF DEATH a. COUNTY			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>Saint Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bernard Nursing Home</u> <u>4385 Maryland Avenue</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>14 Carrswold Place</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>E.</u> Last <u>WOODS</u>			4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1869</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Off. International</u>		11. BIRTHPLACE (City and state or country) <u>Marion, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>David Woods</u>		13b. MOTHER'S MAIDEN NAME <u>Havanna Perkins</u>		14. NAME OF HUSBAND OR WIFE <u>Martha Kevil Woods (late)</u>	
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>none</u>		17. INFORMANT Address <u>Mrs. Robert Arthur 14 Carrswold Plade</u>	
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>Advanced cerebral arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 years.</u>
DUE TO (b) _____					
DUE TO (c) <u>334XH</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma Prostate. Staphylococcus Infection Scalp.</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <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.)	
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 _____	
21. I attended the deceased from <u>1935</u> to <u>12-28-61</u> and last saw ^{from} him alive on <u>December 20, 1961</u> Death occurred at <u>3:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. Edward Clark</u> (Degree or title)			22b. ADDRESS <u>864 Hamilton Blvd.</u> <u>M.D., St. Louis 12, Mo.</u>		22c. DATE SIGNED <u>12-28-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>12/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u>
24. FUNERAL DIRECTOR <u>C.R. Lupton and sons 7233 Delmar Blvd</u>			25. DATE RECD. BY LOCAL REG. <u>DEC 29 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, Mo.

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.