MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8631

1. PLACE OF DEATH

County ..... Registration District No. 1003 (191) File No. .....

Township ..... Primary Registration District No. ..... Registered No. 2302

City St. Louis, Mo. (No. U. S. Marine Hosp. ..... St. ..... Ward)

2. FULL NAME William E. Woolford

(a) Residence. No. Apr. 1, Suffolk, Va. St., 24 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 18 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 28-1884.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	44	10	20	

8. OCCUPATION OF DECEASED

188

(a) Trade, profession, or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer aboard str.

(c) Name of employer x

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Maryland

2

PARENTS

10. NAME OF FATHER James L. Woolford

2

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Maryland

12. MAIDEN NAME OF MOTHER Leah Brevard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Maryland

14. INFORMANT Walter Fehrtner,
(Address) 3640 Marine Ave. St. Louis, Mo.

15. FILED 20 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 18 - 1929.

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, 19..., to Feb. 18, 1929, 19..., that I last saw him alive on Feb. 18, 1929, 19..., and that death occurred, on the date stated above, at 7:25 a.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic pulmonary tuberculosis

23A

(duration) X yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Unknown

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H. T. Gilmer, M. D

2/18, 1929 (Address) 3640 Marine Ave., St. Louis, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. Matthews Cem.	2-20- 1929
20. UNDERTAKER	**ADDRESS**
Ziegenhein Bros. 2623 Cherokee	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.