

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9285
2768
Registrar's No. _____

Registration District No. 291 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1605 A. Missouri Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1605 A. Missouri Ave (Specify whether
years, months or days)

3. (a) PRINT FULL NAME John K. Woods
8. (b) If veteran, name war _____ 8. (c) Social Security No. 492-10-7837

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Addie Woods 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased June 23 1875
(Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Thomas J. Johnson R.E. Co.

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Addie Woods
(b) Address 1605 A. Missouri Ave

17. (a) Burial (b) Date thereof March 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walhalla Cemetery
Peetz Brothers

18. (a) Signature of funeral director _____
(b) Address 3029 Lafayette Ave

19. (a) MAR 25 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 1605 A. Missouri Ave
(If rural, give location)
(e) If born in this State _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 22nd. day March
year 1940 hour 6:00 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Occlusion
arteriosclerosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Joseph M. Peetz (Date of other) _____
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Frank J. Owens

Licensed Embalmer No.....

2745

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 this body is not embalmed, above space should be left blank.