

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **8944**

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: Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 13 Hrs., 45 M.
(Specify whether)
 In this community Life
years, months or days

3. (a) PRINT FULL NAME Claude Woods Jr.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9-26-40
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>1</u>	<u>13 hrs. 45 min.</u>

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Claude Woods

13. Birthplace Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Woods

15. Birthplace Fayette Cty. Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Other Major General
 (b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 10-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Dr. Hamilton

(b) Address City Health Dept

19. (a) OCT 30 1940 (b) J. H. Prebich
(Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
 Street No. 2229a Cass
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 27
 year 1940 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from 9-26-40 to 9-27-40 1940;
 that I last saw him alive on 9-27-40 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis

Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy Same as above

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 W. Smiley (M. D. or other) _____
 Address 2601 N Whittier Date signed 10-28-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

NOV 16 1940

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.