

JAN 15 1941 791
Registration District No. _____

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis **10**
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

8. (a) PRINT FULL NAME ELLA WOODS

8. (b) If veteran, name was _____
8. (c) Social Security No. _____

5. Color or race White
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Undiscovered
(Month) (Day) (Year)

8. AGE: Years 37 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Undiscovered

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

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Powell P. D.

(b) Address 3927 Fleas

17. (a) _____ (b) Date thereof 11-9-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington - Woodlawn

18. (a) Signature of funeral director W. B. Briston

(b) Address 2500 Patton

19. (a) **DEC 4 1940** (b) J. H. Briston
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis **25**
(If outside city or town limits, write "RURAL")
(d) Street No. 1531 Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Oct day 24
year 1940 hour 11:25 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 Chronic Myocarditis

Due to Chronic Nephritis

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

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. Green (M. D. or other) _____

Address Deputy Coroner Date dictated _____

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

MOTHER FATHER

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 with the above constitutes grounds for revocation of license.)

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