

S. No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40972**
16743
Registrar's No.

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH: **St. Louis.**
(a) County **St. Louis, Mo.**
(b) City or town
(c) Name of hospital or institution: **City Infirmary.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **February 17, 1940**
In this community **Not known.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **James Woodward.**
3. (b) If veteran, name war **Not known** 3. (c) Social Security No.

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Widower**
6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive, years **1861**
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 X X hr. min.

9. Birthplace **Not known** (City, town, or county) (State or foreign country)

10. Usual occupation **No Occupation**

11. Industry or business X

12. Name X

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

14. Maiden name **UNKNOWN**

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

16. (a) Informant **E. Molony**
(b) Address **5800 Arsenal St.**

17. (a) (b) Date thereof **12-4-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis, Mo.**

18. (a) Signature of funeral director **W. R. R. R.**

DEC 27 1940 (Date received local registrar)

19. (a) (b) **J. F. Bredbeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis.**
(c) City or town **St. Louis** (If outside city or town limit, write "RURAL") **13**
5800 Arsenal St.
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **3**, year **1940** hour **2:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **February 17, 1938** to **December 3, 1940**, that I last saw him alive on **December 3, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebro-vascular accident - left hemiplegia**
Dehydration
malnutrition
Arteriosclerosis, generalized
Inguinal hernia
Due to
Due to
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **J. F. Bredbeck**
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 **H. P. Bierman, M.D.** (M. D. or other)
Address Date signed

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.