

FILED AUG 7 1943

Registration District No. 318

Primary Registration District No. 1003

6950

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Cole
(c) City or town Charleston
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mack Woodworth

3. (b) If veteran, name war None 3. (c) Social Security No. 354-05-3689

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

6. (b) Name of husband or wife Louise Woodworth 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased October 9 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 9 21 hr. min.

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

10. Usual occupation Railroad laborer

11. Industry or business Railroad

12. Name J. R. Woodworth

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

14. Maiden name Ella Bates

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

16. (a) Informant Mrs. Martha Gannaway

(b) Address Charleston, Illinois

17. (a) Removal (b) Date thereof 7-31-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUL 24 (b) J. F. Brinck
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30 year 1943 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from July 9, 1943, to July 30, 1943

that I last saw him alive on July 30, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death acute post op Peritonitis Duration _____

Due to abdominal-planned resection 4 days

Due to Caecum of Rectum 4 mo

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma of Rectum PHYSICIAN _____

Of autopsy acute Peritonitis 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 Charles Elmer (M. D. or _____)
Address BARNES HOSPITAL Date signed 7/30/43

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

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..... *J. Allen Davis Jr*
Licensed Embalmer No..... *4052*
P. O. Address..... *City*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6950

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(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

3. (a) PRINT FULL NAME Mack Woodworth

3. (b) If veteran name war (World War)

3. (c) Social Security No. (354-05-3689)

4. Sex _____ 5. Color or race _____

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife (Lois Woodworth)

6. (c) Age of husband or wife if alive _____ year

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

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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 _____
(b) Address _____

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

(c) Place: burial or cremation _____

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

19. (a) 8-12-43 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Cole

(c) City or town Charleston
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30th year 1943 hour _____ minute _____ 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 _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-23675