

Registration District No. 318 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:
3949 Iowa 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.....
years, months or days)

3. (a) PRINT FULL NAME Laura C. Woods
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 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 Sept. 10. 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	7	13	hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

MOTHER FATHER { 12. Name Henry Woods
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Fitzwilliams
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Genevieve Woods
(b) Address 3949 Iowa Ave.

17. (a) Burial (b) Date thereof 4/26/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address 2117 E. Grand Blvd.

19. (a) APR 27 1944 (b) [Signature]
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County C. Cole
(c) City or town St. Louis 1924
(If outside city or town limits, write "RURAL")
(d) Street No. 3949 Iowa Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1944 hour 1 P.M. M.
21. I hereby certify that I attended the deceased from Jan 7, 1943 to April 23, 1944
that I last saw h. alive on April 23, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coriary Dilatation Duration 1 day
Due to Chronic Endo Carditis -
mitral insufficiency
Due to Chronic myo Carditis
hypertensive sclerosis
Other conditions (Include pregnancy within 3 months of death)
Major findings: [Signature]
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?

23. Signature [Signature] (Specify type of place) (e) Means of injury.....
Address 4548 Harris St. Date signed 4/22/44

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.....
Frank A. Moore

Licensed Embalmer No. *3041*

P. O. Address. *2117 E. 1st*

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.