

S. No. 2
M-2-43
5-17-39
X33667

#36642
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 27 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39333
10738

State File No. _____
Registrar's No. _____

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution: **St. Louis City Hospital Max C. Starkloff Memorial**
(d) Length of stay: **4 days**
In this community _____
years, months or days) **0**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **MAD**
(c) City or town **St. Louis** (d) Street No. **3001 E McNair**
(e) Citizen of foreign country? **No**
If yes, name country _____

3. (a) PRINT FULL NAME **Donald Wood**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Male**
5. Color or race **white**
6. (a) Single, widowed, married, divorced **U**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Nov. 4, 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 11
hr. min.

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

10. Usual occupation _____

11. Industry or business _____
12. Name **John Wood**
13. Birthplace **Mt. Vernon Illinois**
14. Maiden name **Georgia Takabowski**
15. Birthplace **St. Louis Missouri**

16. (a) Informant **Mrs. John Wood**
(b) Address **3001 E McNair**

17. (a) **Burial** (b) Date thereof **Dec. 18, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope Cem.**

18. (a) Signature of funeral director **Witt Bros. & Co.**
(b) Address **2929 S. Jefferson**

19. (a) **DEC 17 1944** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **15th**
year **1944** hour **4:30** minute _____ P. M.

21. I hereby certify that I attended the deceased from **12/15/44**
19 _____ to **Dec. 15th** 19 **44**
that I last saw him alive on **Dec. 15th** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Diarrhea Malnutrition Epidemic Diarrhea of Newborn**
Due to _____
Due to _____

Other conditions **11/9/44**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **Malnutrition**

Duration **2-3 weeks**
2-3 weeks
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? _____
(Specify type of place) (Means of injury) _____

23. Signature **O. S. Watkins** (M. D. or other) **M.D.**
Address **1515 Lafayette** Date signed **12/16/44**

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 Ronald Yahrke

Licensed Embalmer No. 3917

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, fact should be so stated above.