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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26294

FILED SEP 3 1945

Registration District No. 1003

Primary Registration District No.

Registrar's No. 7734

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: ST LUKE'S 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 PLATT 99

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME GEORGE LOUIS WOOD

3. (b) If veteran, name war NIL

3. (c) Social Security No. NONE

4. Sex MALE

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 FEBRUARY (Month) 17 (Day) 1861 (Year)

8. AGE: Years 84 Months 6 Days 16 If less than one day hr. min.

9. Birthplace PLATT COUNTY (City, town, or county) ILLINOIS (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business

FATHER
12. Name WEEDEN WOODS
13. Birthplace UNKNOWN (City, town, or county) UNKNOWN (State or foreign country)

MOTHER
14. Maiden name AMANDA PECK
15. Birthplace UNKNOWN (City, town, or county) UNKNOWN (State or foreign country)

16. (a) Informant HELEN PARRISH
(b) Address 651 POST PL, EAST ST. LOUIS, ILL.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 9-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation CERROGORDA, ILL

18. (a) Signature of funeral director ALBERT H. HOPPE
(b) Address 4700 WASHINGTON BLVD

19. (a) SEP 4 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 3
year 45 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from 8-21- 1945 to 9-3- 1945
that I last saw him alive on 9-3- 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death My ocerdites + Pneumonia	2 mos.
Due to —	
Due to 93	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. W. Noller (M.D. or other)

Address St. Louis Hosp. Date signed 9-3-45

(Licensed Embalmer's Statement on Reverse Side)

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. Albert L. Hoffer

Licensed Embalmer No. 2971

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.