

FILED JAN 31 1946

State File No.

Registration District No.

Primary Registration District No.

1003

Registrar's No.

11114

1. PLACE OF DEATH:

(a) County.....St. Louis
(b) City or town.....St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
En route to Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....--
In this community.....Life 3 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State.....Mo. (b) County.....19
(c) City or town.....St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.....4407 St. Ferdinand
(If rural, give location)
(e) Citizen of foreign country?.....No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME.....FRENCHIE WOOD

3. (b) If veteran, name war.....-- 3. (c) Social Security No.....No

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

6. (b) Name of husband or wife.....James 6. (c) Age of husband or wife if alive.....68 years

7. Birth date of deceased.....Feb. 14 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>10</u>	<u>2</u>	hr. _____ min.

9. Birthplace.....West Alton Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation.....Housewife

11. Industry or business.....--

12. Name.....James Winston

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

14. Maiden name.....Elizabeth Rhodes

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

16. (a) Informant.....James J. Wood

(b) Address.....4407 St. Ferdinand

17. (a) Burial (b) Date thereof.....12-21-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....Greenwood Cemetery

(a) Signature of funeral director.....Chas. J. Gates

(b) Address.....4107 Finney Ave.

19. (a) DEC 19 1945 (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....Dec. day.....16th
year.....1945 hour.....9:30 minute.....P. M. M.

21. I hereby certify that I attended the deceased from.....July 1st 1945 to.....December 16 1945
that I last saw her alive on.....December 16th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death.....Shock induced by injury sustained in auto collision 12/16/45

Due to.....Hypertension 1 yr.

Deceased suffered from.....Hypertensive Heart Disease
and the accident gave her a severe

Other conditions.....shock which caused death.
(Include pregnancy within 3 months of death)

Major findings: Of operations.....1700-8

Of autopsy.....22

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.....W. J. Wallace (M. D. or other)

Address.....2316a Market St. Date signed.....

STATEMENT BY LICENSED EMBALMER

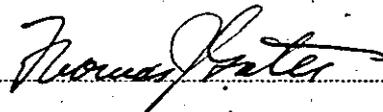
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

, Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 4259

4107 Finney Ave.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11114

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(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 Frenchie Wood
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 14 1902
(Month) (Day) (Year)

8. AGE: Years 60 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 _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

19. (a) 1/15/46 (b) J. F. Predest
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town _____
(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 Dec Day 16 Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 1702 _____ Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) accident
(b) Date of occurrence 12/16/45
(c) Where did injury occur? on street in St Louis
(City or town) (County) (State) MO
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on street

While at work? _____ (Specify type of place) (e) Means of injury auto

23. Signature W. R. YOUNG (M. D. or other) _____
Address 2316 Market Date signed 12/16/46

JAN 17 1946

WRITE PLAINLY—USE UNFADING BLACK INK—MARK A FEMININE RECORD

39967