

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** MAY 27 1946  
**318**

THE STATE BOARD OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**  
1003

State File No. **19072**  
Registrar's No. **4389**

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:  
Homer G Phillips Hspital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 mo; 11 days  
(Specify whether  
 In this community 8 yrs  
years, months or days)

**3. (a) PRINT FULL NAME** James Woolfolk

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

4. Sex male 2. 5. Color or race col  
 6. (a) Single, widowed, married, divorced single  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 27th 1928  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>18</u>	<u>1</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation School boy

**MOTHER, FATHER**

11. Industry or business \_\_\_\_\_

12. Name Norman Woolfolk

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

14. Maiden name Vera Mcfield

15. Birthplace St. Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Norman Woolfolk  
 (b) Address Fa. Irview Ave Robertson Mo

17. (a) burial (b) Date thereof 5-17-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. F. Budek  
 (b) Address 3133 Bell Ave

19. (a) MAY 15 1946 (b) J. F. Budek  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County St Louis Co  
 (c) City or town St Louis Robertson  
(If outside city or town limits, write "RURAL")  
4549 Page  
 (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 May day 11  
 year 1946 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from April 1, 46 to May 11, 46  
 that I last saw him im alive on May 11, 46  
 and that death occurred on the date and hour stated above.

Immediate cause of death Far-Advanced Pulmonary Tuberculosis Duration Unk

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 12  
(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 W. P. Bernard (M. D. or other) \_\_\_\_\_  
 Address 9601 N. Whitney Date signed 5-14-46

**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 *D J Watson*

Licensed Embalmer No *2698*

P. O. Address *2769 Shout*

**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.**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. 4389

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: Homer Phillips 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

3. (a) PRINT FULL NAME James Woolfolk  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Col 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 March - 27 - 1918  
(Month) (Day) (Year)

8. AGE: Years 18 Months 1 Days 14 If less than one year \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredenk (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town Robertson  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) N.R.  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Far advanced Pulmonary Tuberculosis

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 \_\_\_\_\_

SUPPLEMENTAL

MAY 23 1946

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

19072