

S. No. 2
M-5-43
5-17-39
I X36877

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22356
5650

State File No.

Registrar's No.

FILED JUL 3 1946
318

Registration District No. Primary Registration District No.

1003

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

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 Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Hrs. 44 Mins
(Specify whether)

In this community.....
years, months or days)

3. (a) PRINT FULL NAME Infant Woods

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

4. Sex Male 2 5. Color or race Negro

6. (a) Single, widowed, married, divorced C

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife If alive..... years

7. Birth date of deceased. 6 9 46
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 hr. 44 min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Andy Woods

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

14. Maiden name Ruby Baul

15. Birthplace Cation Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur M. Sherard, R.H.

(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof JUN 27 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial CITY CEMETERY

18. (a) Signature of funeral director Y. B. Hudson

(b) Address City Health Dept

19. (a) JUN 27 1946 J. F. Bueck
(Date of local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0702

(c) City or town St. Louis 217
(If outside city or town limits, write "RURAL")

(d) Street No. 2621 Thomas 9
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) 2

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 9
year 1946 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from 9:31 A.M.
6 - 9 1946, 3:15 P.M. 6-9 1946;
that I last saw him alive on 6 - 9 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Prematurity

Due to.....

Due to..... 159

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

Duration

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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 1

23. Signature Chaneick MAX X X DEK

Address 2601 N. Whittier Date signed 6-26-46

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.....

Licensed Embalmer No.....

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.