

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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

State File No. 25881
Registrar's No. 65111

FILED AUG 5 1946
Registration District No. 318

Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... St. Louis
(c) Name of hospital or institution:
Depaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... Mo. (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No..... 4870 Easton Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... Minnie Wood
(b) If veteran, name war..... No
(c) Social Security No..... None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 24
year 1946 hour 6.15 minute A.M. M.
21. I hereby certify that I attended the deceased from
7-19-46 to 7-24-46
that I last saw her alive on 7-23-46
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife..... Osburn L. Wood
6. (c) Age of husband or wife if alive..... year 70

Immediate cause of death.....
Degenerative Myocardiosis
Coronary Atherosclerosis
Chronic Passive Congestion of Lungs
Chronic Passive Congestion of Lungs
Other conditions.....
(Include pregnancy within 3 months of death)

7. Birth date of deceased..... Aug. 9, 1876
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
70 11 15 hr. 14

Major findings:
Of operations.....
Of autopsy as stated above
PHYSICIAN
Underline the cause to which death should be charged statistically.

9. Birthplace..... Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation..... Retired

11. Industry or business.....
12. Name..... James Hrpool
13. Birthplace..... Illinois
(City, town, or county) (State or foreign country)
14. Maiden name..... Almira Dean
15. Birthplace..... Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant..... Bertha Wood
(b) Address..... 4870 Easton Ave.
17. (a) Burial (b) Date thereof..... July 25/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... Memorial Park Cem.

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?.....

18. (a) Signature of funeral director..... JOS. W. Clark
(b) Address..... 1125 Hodiamont Ave.
19. (a) JUL 24 1946 (b) J. F. Bredsek
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place) (c) Means of injury.....
23. Signature..... E. A. Lunsche (M. D. or other) M.D.
Address..... 4865 Natural Bridge Date signed..... 7-29-46

Dr. E.A. Lansche
4885 Natural Bridge Rd.,
MU. 9393. 9-11 A.M.

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 Alfred G. Boedeker
Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.,

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.