

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:
943 Cabanne Court 1
(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 Mary Woods

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

4. Sex Female 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 _____

7. Birth date of deceased: Aug 7, 1903
(Month) (Day) (Year)

8. AGE: Years 44 Months 7 Days 20
If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business _____

12. Name George Woods

13. Birthplace MO.

14. Maiden name KITIE

15. Birthplace MO.

16. (c) Informant Edwina HALL

(b) Address 943 Cabanne Court

17. (a) BURIAL (b) Date thereof MAR 31, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREEN WOOD CEM

18. (a) Signature of funeral director Frank Green

(b) Address 2915 Franklin Ave

19. (a) MAR 31 1947 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

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. 943 Cabanne Ct.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 27
year 1947 hour 10 minute _____ a. M.

21. I hereby certify that I attended the deceased from Mar 17
1947 to Mar 27, 1947

that I last saw her alive on Mar 27, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia Duration 7 days

Due to Laryngitis 10 days

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) (c) Means of injury _____

23. Signature J. F. Bredbeck (M. D. or other) _____
Address 2922 N. Jefferson Date signed 3/29/47

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

MOTHER FATHER

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: *J. A. Shear*.....

Licensed Embalmer No. *2963*.....

P. O. Address *2915 Franklin*.....

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.