No. 2
-1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36441 9284

FILED OCT 24 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: [redacted] 2825a Delmar
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community About 3o years

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County St. Louis, Mo.

(c) City or town
(If outside city or town limits, write "RURAL")

Street No. 2825 A Delmar Bl
(If rural, give location)

21-

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

If yes, name country

3. (a) PRINT FULL NAME Amanda Woods

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Female

5. Color or race Colored

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive No years

7. Birth date of deceased Aug 7th 1877 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
7o	1	27	hr. min.

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

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Frank Jones
13. Birthplace Canton Miss. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Octavia ?
15. Birthplace Miss. (City, town, or county) (State or foreign country)

16. (a) Informant Hattie Transer
(b) Address 2825A Delmar Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1o-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters cemetery

18. (a) Signature of funeral director A. L. Beel Un Co
(b) Address 4303 Delmar Blvd

19. (a) OCT 7 1947 (Date received local registrar) (b) J. T. Beck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4th year 1947 hour 6 pm minute 15 M.

21. I hereby certify that I attended the deceased from Oct 3rd, 1941 to Oct 4th, 1947 that I last saw he alive on Oct 4th, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial pneumonia	5da
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Diabetes Mel. Ill. Tub. Distention in depends	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Thos A Lewis (M. D. or other)
Address 3154 Easton Date signed 10-2-47

Thos. A Lewis

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Vera L. Wilson

Licensed Embalmer No. 4435

P. O. Address 2618 Bailey

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.