

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **6846**
2106

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place) 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 17 9
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2721st Thomas St		
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) _____ c. (Last) Woods		4. DATE OF DEATH (Month) (Day) (Year) Mar. 1 1949		
5. SEX MALE	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 11-21-1905	9. AGE (In years last birthday) 43
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY AMERICAN CAR. CO.		11. BIRTHPLACE (State or foreign country) LELAND Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13a. FATHER'S NAME Wm Woods		13b. MOTHER'S MAIDEN NAME Abbie Little		14. NAME OF HUSBAND OR WIFE Ethel Woods
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Ethel Woods ADDRESS 1611 Cole St
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, Metastatic of the lungs, INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES DUE TO (b) Carcinoma of the Prostate (Primary site) DUE TO (c) Undetermined II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 177K		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from 2-27 , 19 49 , to 3-1 , 19 49 , that I last saw the deceased alive on 3-1 , 19 49 , and that death occurred at 4:30 am. , from the causes and on the date stated above.				
23a. SIGNATURE Herbert J. Corwin (Degree or title) M. D. U.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 3/2/49
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-8-49		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEMETERY
24d. LOCATION (City, town, or county) (State) St Louis County Mo				
DATE REC'D BY LOCAL _____		REGISTRAR'S SIGNATURE J. B. Saper		25. FUNERAL DIRECTOR'S SIGNATURE Ellis FUNERAL HOME ADDRESS 2820 Stoddard

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Fulton E. Culkin

Signed _____
Student Embalmer

Licensed Embalmer No. 4198

P. O. Address St Louis 13. Mo

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.