S. No. 300
v. 10-48

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28694

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7138

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, 110
c. LENGTH OF STAY (in this place): 25 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Peoples Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 2419 N. Taylor

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle): Belle
c. (Last): Woolfolk

4. DATE OF DEATH (Month) (Day) (Year): Aug. 11 - 1949

5. SEX: F
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug 28, 1874
9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lexington, Ky.
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Joseph Baker
13b. MOTHER'S MAIDEN NAME: Winnie Jackson
14. NAME OF HUSBAND OR WIFE: Thomas Woolfolk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Lillian Woolfolk
ADDRESS: 2419 N. Taylor

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of stomach
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): 0
DUE TO (c): 0

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Cancer / Dog

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 46
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 151

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* Aug 11, 1949, *that I last saw the deceased alive on* Aug 11, 1949, *and that death occurred at* 10.12 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): D. Neale Williams M.D.
23b. ADDRESS: 501 Madison Lovejoy Ill
23c. DATE SIGNED: Aug 15

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Aug. 17, 1949
24c. NAME OF CEMETERY OR CREMATORY: Cherry Grove
24d. LOCATION (City, town, or county): Cynthiana (State): Ky.

DATE REC'D BY LOCAL: AUG 16 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Beal Undertaking Co.
ADDRESS: 4303 Delmar

(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 ..... Student Embalmer No. ..... working under my personal supervision.

Student .....
Student Embalmer

Signed Gordon I Yandell

Licensed Embalmer No. 4243

P. O. Address 14 Waymire

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.