

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34358

State File No.

FILED OCT 9 1953

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>Wellston</u> <u>4311</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Faith Hospt.</u>				e. STREET ADDRESS (If rural, give location) <u>1110 Delaware Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Henry</u> c. (Last) <u>Woolbright</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 2/53</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 16 1867</u>	
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>? Ala.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13a. FATHER'S NAME <u>? Woolbright</u>			13b. MOTHER'S MAIDEN NAME <u>Dont Know</u>			14. NAME OF HUSBAND OR WIFE <u>Cora Woolbright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give particulars of service) _____			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Cora Woolbright 1110 Delaware Ave</u>	
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) <u>CEREBRAL HEMORRHAGE</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 DAY</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) <u>331X</u>			
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 <u>Aug 30, 1953</u> , to <u>SEPT 2, 1953</u> , that I last saw the deceased alive on <u>9-2, 1953</u> , and that death occurred at <u>12:05 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>O M.D.</u>				23b. ADDRESS <u>1194 HODIAMONT AVE</u>		23c. DATE SIGNED <u>9-2-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Sept. 3/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wellis Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Jonesboro Ark.</u>	
DATE REC'D BY LOCAL REG. <u>SEP 3 1953</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos. W. Clark 1125 Hodiamont Ave.</u>			

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

H. P. O. White
Holloman - one
M.D.

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.....
Signature of Student Embalmer

Signed..... *Paul A. Wachter*

Licensed Embalmer No. *478*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.