

FILED NOV 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36151**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9611**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>5 yrs</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis Mo. 219</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips</b>		d. STREET ADDRESS (If rural, give location) <b>3810<sup>2</sup> Del Mar</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>Edna</b>	b. (Middle)	c. (Last) <b>Woods</b>	<b>10</b>		<b>21</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1-16-1904</b>		9. AGE (In years last birthday) <b>50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Unk</b>		13b. MOTHER'S MAIDEN NAME <b>Unk</b>	
14. NAME OF HUSBAND OR WIFE <b>William Woods</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>William Woods</b>		ADDRESS <b>3810 Del Mar</b>			

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio sclerosis; Inhalation of gas; suffered when over</b>		DUE TO (c) <b>Gas</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Oct 20, 1954, exact time unknown</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>Accident</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Mo</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Oct 20, 54</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>E8900</b>	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred <b>at NOON</b> , _____, 19____, from the causes and on the date stated above. <b>14</b>					
23a. SIGNATURE (Degree or title) <b>Matriel (Taylor) Carraway</b>		23b. ADDRESS <b>1200 Pearl</b>		23c. DATE SIGNED <b>10-23-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Item</b>		24b. DATE <b>10-25-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Barracks</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis Co Mo</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Manuel Vnd. Co</b>		ADDRESS <b>4059 Finney</b>	
DATE REC'D BY LOCAL REG. <b>OCT 23 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>			

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

1959

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 *H. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

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.