

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **44149**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11636**

1. PLACE OF DEATH a. COUNTY		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)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 21 3036 Easton Avenue			
3. NAME OF DECEASED (Type or Print)		a. (First) Solomon	b. (Middle)	c. (Last) Woods	4. DATE OF DEATH (Month) (Day) (Year) 12 - 9 - 54
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2		8. DATE OF BIRTH 3-2-1875	9. AGE (In years last birthday) 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Illinois /	
13a. FATHER'S NAME Unk.		13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) None		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME Blumen	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			ADDRESS 2601 N. Whittier
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH Undet.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4500	
22. I hereby certify that I attended the deceased from 12-5-54 , 19 54 to 12-9- , 19 54 , that I last saw the deceased alive on 12-9- , 19 54 , and that death occurred at 10: a.m. , from the causes and on the date stated above.					
23a. SIGNATURE C. B. Williams		(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier Street	
23c. DATE SIGNED 12-15-54					
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-31-54		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. DEC 22 1954		REGISTRAR'S SIGNATURE J. Carl Smith Mo		25. FUNERAL DIRECTOR'S SIGNATURE Kowland-Aker Mortuary Service	
				ADDRESS 4194 Manchester Ave St. Louis 13, Mo.	

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.