

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023553

FILED JUL 1 1959

Registration District No. Primary Registration District No.

STATE FILE NO. 2 5832

300  
-57  
3

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hospital		d. STREET ADDRESS (If outside, give location) 2721 Gamble	
Length of stay in lb 3mo 23dys		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Henry Woods			4. DATE OF DEATH Month Day Year June 17, 1959		
---	--	--	---	--	--

5. SEX male 2	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1887	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 1 Days 2	IF UNDER 24 HRS Hours Min.
------------------	-----------------------------	---	-------------------------------	---------------------------------------	------------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Aberdeen, Miss. 1	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	-------------------------------------

13a. FATHER'S NAME Henry	13b. MOTHER'S MAIDEN NAME Dolphus	14. NAME OF HUSBAND OR WIFE
-----------------------------	--------------------------------------	-----------------------------

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 Willie Bell Dunlap	Address 2715 Gamble Street
--	------------------------------	-------------------------------------	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	177+
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerotic Heart Disease - 4 mo.</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--	---

21. I attended the deceased from <u>Feb. 25, 1959</u> to <u>June 17, 1959</u> last saw her alive on <u>June 17, 1959</u> Death occurred at <u>5:10 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <i>John W. Beckham, M.D.</i>	(Degree or title) 0	22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED <i>6/18/59</i>
--	---------------------	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <i>6-20-59</i>	23c. NAME OF CEMETERY OR CREMATORY Father Dickson	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
--	-----------------------------	--	---

24. FUNERAL DIRECTOR Ellis Funeral Home	ADDRESS 2820 Stoddard St.	25. DATE RECD. BY LOCAL REG. JUN 19 59	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.P.</i>
--	------------------------------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Fulton G. Culbert* .....

Licensed Embalmer No. *4198* .....  
P. O. Address *Atlanta* .....

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.