

# FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE

## FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042743

FILED VS DEC 8 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **210995** STATE FILE NUMBER

12/14/59  
 11/20/1959  
 W.S.A.  
 U.S.A.  
 U.S.A.  
 U.S.A.

DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF Funeral Director

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>6 Days</b>		a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>Shrewsbury</b> d. STREET ADDRESS <b>7611 Devonshire Ave.</b>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		e. RESIDE ON FARM (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>ELLEN</b> Last <b>WOODARD</b>				4. DATE OF DEATH <b>November 27, 1959</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/1897</b>		
9. AGE (last birthday) <b>62</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____				
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 <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>La Junta, Col.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Richmond V. Ford</b>			13b. MOTHER'S MAIDEN NAME <b>Stella Boatwright</b>			14. NAME OF HUSBAND OR WIFE <b>Harold S. Woodard</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. H.S. Woodard, 7611 Devonshire</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
IMMEDIATE CAUSE (a) <b>Sudden Generalized Convulsions</b>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Conduction of left tract</b>		DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>170x</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m.		Month, Day, Year _____						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>11-22-59</b> to <b>11/26/59</b> and last saw her alive on <b>11/25/59</b> . Death occurred at <b>11/27/59 1:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Robt. Mueller</b> (Degree or title)			22b. ADDRESS <b>975 Arcade Bldg.</b>			22c. DATE SIGNED <b>11/27/59</b>		
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Removal</b>		23b. DATE <b>11/30/1959</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>NOV 28 1959</b>		26. REGISTRAR'S SIGNATURE <b>Coal Smith M.D.</b>		

Dr. Robt. Mueller

Arcade Bldg. 812 Olive

CE 1-3846

Till 5:30 PM Fri.

975

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Jos. E. Mueller*

Licensed Embalmer No. 276

P. O. Address 6125 P. O.

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.