MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. ✓

6032

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. City Hospital ..... St. ..... Ward)

File No. .....

Registered No. 1216

2. FULL NAME 1397 George B. Woods

(a) Residence. No. 1327 N Spring St. 19 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 25 - 1863

7. AGE: Years 63 | Months 4 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Printer 131 10 9 69
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

PARENTS

10. NAME OF FATHER Arthur Woods

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

12. MAIDEN NAME OF MOTHER Charlotte Fullerly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED FEB - 3 1927, 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH ✓

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 1 1927

17. I HEREBY CERTIFY That I attended deceased from June 20, 19 26 to Feb 1, 19 27 that I last saw him alive on Feb 1, 19 27 and that death occurred, on the date stated above, at 8:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia

Chronic Nephritis, Parenchymatous (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) ..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature] M. D

2/2, 19 27 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mo Crematory

DATE OF BURIAL: 2-4 1927

20. UNDERTAKER: Mr Schumacher

ADDRESS: 3013 Miramar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

...RNET, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Woods.