

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

Do not use this space.

9607

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo. (No. Sanitarium)..... St. Ward).....

File No.....
 Registered No. 2121

2. FULL NAME

William Wood
 (a) Residence, No. 3301 Cambridge St. 13 Ward. Maplewood Mo.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 1, 1883

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>43</u>	<u>4</u>	<u>3</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Locomotive Engineer
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer Terminal Railway

9. BIRTHPLACE (CITY OR TOWN) Washington
 (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT K. S. Sherrill
 (Address) City Base

15. FILED Nov 11 1927
Max C. Stavroff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-3-1927

17. I HEREBY CERTIFY, That I attended deceased from 12-1-1925, to 3-3-1927
 that I last saw alive on 3-2-1927, and that death occurred, on the date stated above, at 8:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho pneumonia

1050 (duration) yrs. mos. 9 ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) K. S. Sherrill, M. D.
3-3-1927 (Address) City Base

*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 Memorial Park DATE OF BURIAL Mar. 5 1927

20. UNDERTAKER Petty Bros. 3029 Lafayette

K. 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.

THIS IS A PERMANENT RECORD

