

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

Do not use this space.

27412

1. PLACE OF DEATH
 County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. _____
 City Camas City, Mo. (No. 2546) Jefferson St. _____ Ward _____
2. FULL NAME Ernestine Woodrow
 (a) Residence No. 2546 Jefferson St., 3 Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 27412
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female | **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 Julius Woodrow

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 19 - 1848

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>79</u>	<u>11</u>		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home
 (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) Germany

10. NAME OF FATHER John Erdmann

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

12. MAIDEN NAME OF MOTHER not known

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

14. INFORMANT Julius Woodrow
 (Address) 2546 Jefferson

15. FILED 8/26 1928 M. M. Grove
 REGISTRAR Asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Aug 19, 1928 that I last saw her alive on Aug 18, 1928, and that death occurred, on the date stated above, at 4:45 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Paralysis
8211
15 B 71
 (duration) 2 yrs. mos. ds.
CONTRIBUTORY Arteriosclerosis
 (SECONDARY) (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. X
 DID AN OPERATION PRECEDE DEATH? no. DATE OF _____
 WAS THERE AN AUTOPSY? no.
 WHAT TEST CONFIRMED DIAGNOSIS? General symptoms
 (Signed) J. K. Robinson, M. D.
 (Address) 570 Althea Rd.

*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 Forest Hill cemetery DATE OF BURIAL Aug 22 1928
20. UNDERTAKER John W. Wagner ADDRESS 1409 Grand Ave

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.

DEPARTMENT RECORD

57

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175 1/2