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

Do not use this space.

12931

1. PLACE OF DEATH

County ..... Registration District No. 3937 Walsh St. 1003

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

City St. Louis (No. 3937 Walsh St. ..... Ward)

File No. ..... Registered No. 3482

2. FULL NAME Female Infant of Wm & Eva Wodick

(a) Residence. No. 3937 Walsh St. ..... 15 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: Female

4. COLOR OR RACE: White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 20-1929

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

8. OCCUPATION OF DECEASED: —

(a) Trade, profession, or particular kind of work .....

(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): St. Louis Mo.

PARENTS

10. NAME OF FATHER: William Wodick Co

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Mo.

12. MAIDEN NAME OF MOTHER: Eva L. Johnson

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

14. INFORMANT (Address): J. W. Kerner, Coroner's Office

15. FILED ..... 19 29 Max C. Starkey, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 20 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth

7½ Mo. Gest.

157 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Cause Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1610 W

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner, M.D.

3/20, 1929 (Address) Dep. Coroner

*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: Concordia Cemt

DATE OF BURIAL: March 21st 1929

20. UNDERTAKER: J. H. Gebhen L. & U. Co.

ADDRESS: 2628 Gravois

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD