

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

Do not use this space.

22512

27 1929

PLACE OF DEATH

County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6038B
 City Cent. Lawn (No. 4214 Beachwood Ave. St. _____ Ward)

File No. _____
 Registered No. 211

2. FULL NAME William H. Woodard
 (a) Residence No. 4214 Beachwood Ave Ward. _____
 (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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>11</u>	<u>12</u>	<u>14</u>

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Carpenter retired
 (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) New York

10. NAME OF FATHER Wm Woodard

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs Anna Woodard
 (Address) 4214 Beachwood Ave

15. FILED 7/29 1929 Green Dwyer M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 5:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Thrombosis
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Arterio-sclerosis
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? Not at place of death

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Medical History & X-ray
 (Signed) John O. Bauer
7/30 1929 (Address) Flower & Sullivan St

*State the DISEASE CAUSING DEATH, or in death from VICIOUS 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 7-2 1929

20. UNDERTAKER Geo. L. Pleitseh ADDRESS 5966 Easton Ave.

WRITE PAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

96 JUL 19 11 29 2 3!

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