

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

Do not use this space.

6117

1. PLACE OF DEATH

County St. Charles Registration District No. 757
 Township St. Charles Primary Registration District No. 3036
 City St. Charles (No. 336 S., Main St. St. _____ Ward)

2. FULL NAME Hugh Woolfolk

(a) Residence. No. 336 S. Main St. St. 1 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 44 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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 7, 1883

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>46</u>	<u>11</u>	<u>16</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Reamer.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Troy,
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Anderson Woolfolk

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known.
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Harriet Dyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Montgomery
 (STATE OR COUNTRY) County, Missouri

14. INFORMANT Mrs. Lottie Woolfolk
 (Address) 336 S. Main St.

15. FILED 2/24 1930 Hy S. Blockbaum
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 23, 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-15-30, 1930, to 2-23-30, 1930 that I last saw ~~him~~ her alive on 2-22-30, 1930, and that death occurred, on the date stated above, at 7 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A
23B (duration) 5 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Hemorrhage
 (duration) _____ yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) [Signature] M. D.

, 19 _____ (Address) 2004 Main St. St. Charles, Mo.

*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 Oak Grove Cemetery DATE OF BURIAL Feb. 25, 1930.

20. UNDERTAKER Steinbrinker Furn. Co. ADDRESS St. Charles, Mo.

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.

PARENTS

28 1930

260

31

