

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

Do not use this space.

11481

File No. 105
 Registered No. _____
 St. _____ Ward _____

1. PLACE OF DEATH

9/5 County St. Louis
 Township CARONDELLE
 City _____ (No. _____)

Registration District No. 1123
 Primary Registration District No. 247 E

2. FULL NAME

(a) Residence. No. 6449 Wellmore St. _____ Ward _____
 (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. (If nonresident, give city or town and State)

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 Mellie Hoodson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 1 - 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
41

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Street Car Conductor
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Tenn
 (STATE OR COUNTRY)

10. NAME OF FATHER Ira Hoodson

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

12. MAIDEN NAME OF MOTHER Vertae Harrison

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

14. INFORMANT Mellie Hoodson
 (Address) 6449 Wellmore

15. FILED 5-19-31 L. C. Obrock

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17 1931

17. I HEREBY CERTIFY, That I attended deceased from 3-4-31, 1931, to 3-17, 1931, that I last saw him alive on 3-17, 1931, and that death occurred, on the date stated above, at 2:15 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23 A
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Home

19. DID AN OPERATION PRECEDE DEATH m DATE OF _____

20. WAS THERE AN AUTOPSY? m

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Charles W. Chiers M. D.

, 19 (Address) 9101 So Broadway

*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 DATE OF BURIAL

Valhalla Cemetery 3-20 19 31

20. UNDERTAKER ADDRESS

Geo. L. Pleitach 5966 Easton

WHITE PLAINLY, 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.

APR 27 1931

40 - 7 - 16

...the ...
...in ...

...the ...
...of ...

IRW

...Every item ...
...OR ...

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PLACE OF DEATH.

County St. Louis Registration District No. 1123 File No. _____
 Township Carondelet Primary Registration District No. 6248 Registered No. 123-
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Oscar Woodson
 (a) Residence. No. _____ St. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1 - 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
40 7 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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) _____

10. NAME OF FATHER _____

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 (Address) _____

15. FILED Aug 10 31 L.C. O'Brady REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/17 19 31

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D. _____, 19 _____ (Address)

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

THIS IS A PERMANENT RECORD

should be stated EXACTLY. PHYSICIAN'S Signature: Exact statement of OCCUPATION is very

UNTIL THEY ARE COMPLETE AS PRESCRIBED

STATE PLAINLY, WITH UNFOLDING

N. B. e. Item of information should be carefully supplied CAUSE OF DEATH in plain terms, so that it may be proper

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATION

SUPPLEMENTARY

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