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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13109

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 3314

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin

(c) City or town Zeigler NR
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ellis G. Woodward 363

3. (b) If veteran, name war None

3. (c) Social Security No. 361-09-5447

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Narcissa Woodward

6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 12, 1865.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
74	6	27	hr. min.

9. Birthplace Antiquity (City, town, or county) Ohio. (State or foreign country)

10. Usual occupation Coal Miner 1

11. Industry or business 1 2 10 98

FATHER
12. Name Elihu Woodward
13. Birthplace Unknown (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Elihu G. Woodward
(b) Address Fort Smith Arkansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/10/40 (Month) (Day) (Year)
(c) Place: burial or cremation Fort Smith Arkansas

18. (a) Signature of funeral director Albert H. Hoppe Inc
(b) Address 4700 Washington Blvd.

19. (a) APR 10 1940 (Date received local registrar) J. F. Barbeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9
year 1940 hour 9 05 minute A M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Traumatic Haemorrhage due to Laceration of Lungs by Fractured Ribs and Fracture of Sacrum Suffered in Auto Accident

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) Died 9 00 AM April 8-1940 Near Salem Ill.

Major findings: Of operations Cause and Manner and other particulars of sa could not be determined

Of autopsy Open Verdict

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Open Verdict
(b) Date of occurrence 4/8/40
(c) Where did injury occur? Near Salem Ill (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)
While at work? (e) Means of injury Auto

23. Signature Joseph M. Lewis (M. D. or other)
Address Deputy Co. Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Albert H. Kempe

Licensed Embalmer No. 1861

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.