

16995

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 4473

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4373 West Pine
(If not to hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Cora Woolford Lashly 240

8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife George W. Lashly 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 6 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

FATHER { 12. Name Jacob Woolford
13. Birthplace ILLINOIS
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Julia HARST
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. Lashly
(b) Address 511 130th part Ave

17. (a) Burial (b) Date thereof 5/20/40
(Burial, cremation, or removal) (Month) (Day) (Year)
Lake Charles

18. (a) Signature of funeral director Edith E. Ambruster
(b) Address 4234 Manchester

19. (a) MAY 20 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL") 19
(d) Street No. 4373 West Pine
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1940 hour 11.00 P. M. Minute _____ M.

21. I hereby certify that I attended the deceased from Nov 11
1934 to May 18 1940
that I last saw her alive on May 18 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1 day

Due to Arteria sclerosis 6 yrs

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature A. J. Helbing (M. D. or other) _____
Address 4963 Columbia Date signed 5/19/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Rev. 5-17-39
Form 1 X1931

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.

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.....

Thomas Eynock

Licensed Embalmer No.....

1284

P. O. Address.....

St Louis Mo

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

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