

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

AUG 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23307
Registrar's No. 5752

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2400a Goode Ave.
(If not in 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 _____

3. (a) PRINT FULL NAME Edward Woodson 325

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Ellen Woodson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3 19 1847
(Month) (Day) (Year)

8. AGE: Years 93 Months 3 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Nil

11. Industry or business _____

12. Name Wash Woodson

18. Birthplace _____
(City, town, or county) (State or foreign country) Mo.

14. Maiden name Wink

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bertha Keyson

(b) Address 2400 Goode Ave

17. (a) Burial (b) Date thereof 7/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Russell Und. Co.

(b) Address 2732 Pine Street

19. (a) JUL 8 1940 (b) J.F. Frederick
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2400a Goode Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 5
year 1940 hour 12 minute 15 M.

21. I hereby certify that I attended the deceased from 7 to 7 1940, to 7 5 1940, that I last saw him alive on 7-5 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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) _____
(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? _____

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

23. Signature Wm. Le Bouché (M. D. or other) _____
Address 414 N. 2nd St. Date signed _____

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 *Joel Russell*

Licensed Embalmer No. *4112*

P. O. Address

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.