DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33664 8361

NOV 16 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

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.

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: Phillips Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether In this community 12 years years, months or days)

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. 4374 Fairfax (If rural, give location)

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

3. (a) PRINT FULL NAME Nettie King

3. (b) If veteran, name war ------

3. (c) Social Security No. --------

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Tony Woods

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

7. Birth date of deceased August (Month) 16th. (Day) 1884 (Year)

8. AGE: Years 56 Months 1 Days 20 If less than one day hr. min.

9. Birthplace New Madrid (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housework

11. Industry or business

MOTHER FATHER

12. Name John King

13. Birthplace Unavailable (City, town, or county) (State or foreign country)

14. Maiden name Marie Wade

15. Birthplace New Madrid (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Lydia Thuller

(b) Address 1034a Eureka Flats

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. Gates

(b) Address 4107 Finney Avenue

19. (a) OCT 8 1940 (Date received by registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6 year 1940 hour 8:30 minute P M.

21. I hereby certify that I attended the deceased from Sept 27, 40, to October 6, 1940; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 wks
Due to: Hypertension	Unk
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. W. Johnson (M. D. or other)

Address 2601 N Whittier Date signed

(Licensed Embalmer's Statement on Reverse Side)

10-6-40

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.....

James A. Johnson, Registered Apprentice No.....

working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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

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