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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43881

FILED JAN 10 1944
Registration District No. 217

Primary Registration District No. 6076

State File No. _____
Registrar's No. 2977

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

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town OVERLAND, MO.
(c) Name of hospital or institution:
8932 TUDOR AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 2 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS
(c) City or town OVERLAND
(d) Street No. 8932 - TUDOR AVE
(e) Citizen of foreign country? NO
If yes, name country _____

3. (a) PRINT FULL NAME FLORENCE ELLEN WOODS

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

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W. 2
6. (b) Name of husband or wife JOHN 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JAN 20 1897
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 11 10 hr. _____ min.

9. Birthplace VATES CITY ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name UNKNOWN
13. Birthplace _____
14. Maiden name SARAH BISHOP
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant BERNISE GREGORY

(b) Address 8932 TUDOR AVE.

17. (a) REMOVABLE (b) Date thereof 12-30-43
(Special occasion, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ROCK ISLAND, ILL.

18. (a) Signature of funeral director Wm. J. Broderick
(b) Address 7504 Woodson Rd. Overland, Mo.

19. (a) JAN 3 - 1944 (b) E. J. Gaven, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 30
year 1943 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 25, 1943, to Dec 30, 1943
that I last saw her alive on Dec 30, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Bilateral lobar pneumonia
fracture of hip (rt)
Due to _____
Duration 2 days
5 days

Due to _____
Other conditions (Include pregnancy within 3 months of death) None

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) Fallout of bed
(b) Date of occurrence 12/26 Dec 22, 1943
(c) Where did injury occur? None 8932 Tudor Ave.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

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

23. Signature W. J. Broderick (M. D. or other) M.D.
Address 966 1/2 Kessler Rd. Date signed 12-30-43

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: Oscar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 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, fact should be so stated above.