S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 4 1945

Registration District No. 3179

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18288

Primary Registration District No. F 6076

Registrar's No. 1145

1. PLACE OF DEATH

(a) County: St Louis

(b) City or town: Koch (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 104 days (Specify whether years, months or days)

In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: —

(c) City or town: St Louis (If outside city or town limits, write "RURAL")

(d) Street No.: 815 S. 18th (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Alexander Woodson Toast

3. (b) If veteran, name war: —

3. (c) Social Security No. 489-18-9428

4. Sex: M

5. Color or race: N

6. (a) Single, widowed, married, divorced: widower

6. (b) Name of husband or wife: Annie Toast

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

7. Birth date of deceased: 3 (Month) 28 (Day) 84 (Year)

8. AGE: Years 61 Months 0 Days 28 If less than one day hr. min.

9. Birthplace: St Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Woodson Toast
13. Birthplace: Richmond (City, town, or country) Va (State or foreign country)

MOTHER
14. Maiden name: Mary Ray
15. Birthplace: St Louis County (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Hospital Record
(b) Address: Robt Koch Hospital

17. (a) cremation (Burial, cremation, or removal) (b) Date thereof: 4 30 45 (Month) (Day) (Year)
(c) Place: burial or cremation:

18. (a) Signature of funeral director: City of St Louis
(b) Address: 4th Floor - City Hospital Morgue

19. (a) MAY 14 1945 (Date received local registrar) (b) C. P. McGaughey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26 year 1945 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from 1-12, 1945, to 4-26-1945 that I last saw him alive on 4-26-1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 10 Mth(s)

Due to: 13b

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

23. Signature: Bernard Freeman (M. D. or other) M.D.
Address: Robert Koch Hosp. Kal Mo Date signed 4/26/45

(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.....

Licensed Embalmer No.....

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, fact should be so stated above.