

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

**FILED** JAN 5 1946  
Registration District No. **318**

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**  
(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(c) Name of hospital or institution: St. Louis City Hospital—Max C. Starkloff  
(If not in hospital or institution, write street number or location) Memorial  
(d) Length of stay: In hospital or institution 1 newborn  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

**3. (a) PRINT FULL NAME:** BABY WOOD #2.  
**3. (b) If veteran,** \_\_\_\_\_ **3. (c) Social Security** \_\_\_\_\_  
name war. \_\_\_\_\_ No. \_\_\_\_\_  
**4. Sex:** male **5. Color or race:** white  
**6. (a) Single, widowed, married, divorced, single:** newborn  
**6. (b) Name of husband or wife:** \_\_\_\_\_ **6. (c) Age of husband or wife if alive:** \_\_\_\_\_ years  
**7. Birth date of deceased:** D cember 5th, 1945  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
			hr. min.
<u>8</u>	<u>hours</u>		

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

**10. Usual occupation:** \_\_\_\_\_

**11. Industry or business:** \_\_\_\_\_

**12. Name:** Frank Wood  
**13. Birthplace:** Texas  
(City, town, or county) (State or foreign country)  
**14. Maiden name:** Vivian Thomas  
**15. Birthplace:** Ark.  
(City, town, or county) (State or foreign country)

**16. (a) Informant:** M. Renard  
**(b) Address:** St. Louis City Hospital

**17. (a) Cremation (b) Date thereof:** 12-30-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place:** City Crematory

**18. (a) Signature of funeral director:** W. J. White

**(b) Address:** City Hospital No. 1

**19. (a) DEC 20 1945 (b) J. F. Bredeck**  
(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. 4420 Connecticut St.,  
(If rural, give location) no  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Dec. day 6th  
year 1945 hour 4:55 minute A M.  
**21. I hereby certify that I attended the deceased from** 12/5/45  
\_\_\_\_\_, 19\_\_\_\_, to 12/5/45, 19\_\_\_\_;  
that I last saw h. im alive on 12/5/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity **Duration**  
Suicidal behavior  
Due to \_\_\_\_\_  
Due to 160  
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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
**23. Signature:** George N. Donnell (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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**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.**