

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1005

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 U. Starkloff
(d) Length of stay: In hospital or institution
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County ad
(c) City or town St Louis 17
(d) Street No. 2909a Barrett str 9
Memorial (If rural, give location) 0
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME DAVID WOODWARD
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 25th
year 1948 hour 4 minute 05 P.M.
21. I hereby certify that I attended the deceased from 1/31/48
to Feb. 25th 19.48
that I last saw him alive on Feb. 25th 19.48
and that death occurred on the date and hour stated above.

4. Sex Male O 5. Color or race White
6. (a) Single, widowed, married, divorced Singel O
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August 9 1908
(Month) (Day) (Year)

Immediate cause of death
Carcinomatosis
Due to Chorio epithelioma testis -
Due to
Other conditions
Major findings:
Of operations
Of autopsy

8. AGE: Years 39 Months 6 Days 16
If less than one day hr. min.

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

10. Usual occupation Vet. Administration

11. Industry or business 4300 Brotherhood

12. Name David C Woodward

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

14. Maiden name Theresa Shepard

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

16. (a) Informant Harry Shepherd

(b) Address 2909 a Barrett Str.

17. (a) Burial (b) Date thereof 2/28/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Central Und. Co
(b) Address 1841 Cass ave

19. (a) FEB 27 1948 (b) J. F. Brudeck
(Date received from registrar) (Registrar's signature)

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 E. M. Fullman (M. D. or other)
Address 1515 Lafayette 2/25/48
Date signed

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

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 E. Lma R. Cadwell

Licensed Embalmer No. 4077

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.