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1906

FILED SEP 24 1948

318

1003

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 30. Yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1113 Biddle St
(If rural, give location)
(e) Citizen of foreign country? 25 (Yes or No)
If yes, name country

3: (a) PRINT FULL NAME Lottie Woolfork Majors

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

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Aug 4 1885
(Month) (Day) (Year)

8. AGE: Years 63 Months I Days 8 If less than one day hr. min.

9. Birthplace Hanson Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business

12. Name Henry Woolfork

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

14. Maiden name Margaret White Kentucky

15. Birthplace Hanson Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Harris Woolfork

(b) Address Clay Kentucky

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18-48
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Dale Cemetery

18. (a) Signature of funeral director J. F. M... ..

(b) Address 2769 Chouteau

19. (a) SEP 17 1948 (Date received local registration) J. F. M... .. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1948 hour 7 minute 15 a. M.

21. I hereby certify that I attended the deceased from Sept. 8 19 48 to Sept. 12 19 48
that I last saw her alive on Sept. 12 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Arteriosclerosis
Uremia

Due to 12/1

Other conditions Prob. Nephrosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy NO

Duration Undet.
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) (c) Means of injury 0

23. Signature Ascar J. Daniels (M. D. or other) 0
Address 2601 N Whittier Date signed 9/14/48

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

MOTHER FATHER

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

Lyne Hall

Registered Apprentice No. *221*

working under my personal supervision.

Signed

S. J. Watson

Licensed Embalmer No. *2698*

P. O. Address *2769 Chouteau*

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.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8135

1. PLACE OF DEATH:

(a) County St. Louis City
(b) City or town St. Louis City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Lothe W. Mayo's

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

4. Sex M 5. Color B race _____ 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 63 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. J. Bredeck (Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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