

FILED NOV 19 1948 318  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 9720

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS, MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Barnes Hospital, D  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 DAYS  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Womack James

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Bessie Womack 6. (c) Age of husband or wife if alive 55 years 18 February 18 1868  
7. Birth date of deceased. (Month) (Day) (Year)

AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>8</u>	<u>20</u>	_____ hr. _____ min.

9. Birthplace Texas County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor

11. Industry or business \_\_\_\_\_

12. Name Stanford Womack

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

14. Maiden name Armintha Whittacker

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

16. (a) Informant Mrs. Bessie Womack

(b) Address Houston, Missouri

17. (a) Burial (b) Date thereof 11/8/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Houston, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) NOV 8 1948 (b) J. B. Pasater  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Texas 907  
(c) City or town HOUSTON  
(If outside city or town limits, write "RURAL")  
(d) Street No. NR (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 8th  
year 1948 hour 2:10 minute A.M.

21. I hereby certify that I attended the deceased from Oct. 31, 1948 to Nov. 8, 1948  
that I last saw him alive on NOV. 8, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation Duration 7 days

Due to Myocardial infarct 2 wks.

Due to Atherosclerotic Heart Disease 20 yrs.

Other conditions Atherosclerotic Nephrosclerosis with uremia 2 wks.  
(Include pregnancy within 3 months of death)

Major findings: 12/21  
Of operations \_\_\_\_\_

Of autopsy Atherosclerotic Heart Disease

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 B. Todd Foyt (M. D. or other) M. D.  
Address Barnes Hospital Date signed 11/8/48

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

JUL 1 1949

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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.....

*Guy W. Wilkerson*

Licensed Embalmer No. 3575

P. O. Address. *St. Louis 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.**