

No. 300  
10-48  
46

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32417

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 4015

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>	
c. LENGTH OF STAY (in this place) <u>20 years</u>		d. STREET ADDRESS (If rural, give location) <u>1014 East Linden</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CHARLES</u>	b. (Middle) <u>H</u>	c. (Last) <u>WOKER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 27, 1949</u>
-------------------------------------	---------------------------	----------------------	------------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 23 1876</u>	9. AGE (In years last birthday) <u>72</u>	# UNDER 1 YEAR Months _____	# UNDER 1 YEAR Days _____	# UNDER 1 HRS. Hours _____	# UNDER 1 HRS. Min. _____
--------------------	-------------------------------	---	--------------------------------------	---	-----------------------------	---------------------------	----------------------------	---------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Supplies</u>	11. BIRTHPLACE (State or foreign country) <u>Hofman, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>Henry Woker</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Holzhauer</u>	14. NAME OF HUSBAND OR WIFE <u>Lena Neuhaus Woker</u>
---------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>494-09-8883</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Miss Olinda Woker</u>	ADDRESS <u>1014 East Linden</u>
--	--	--	---------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardiovascular disease</u>		
	DUE TO (c) <u>old infected draining sinus from Rt inguinal herniorrhaphy</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>331X</u> <u>6 mo.</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>331X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from Sept. 26, 1949, to Sept. 27, 1949, that I last saw the deceased alive on Sept. 27, 1949, and that death occurred at 1:45a m.; from the causes and on the date stated above.

23a. SIGNATURE <u>R. R. Coker, M.D.</u> (Degree or title)	23b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	23c. DATE SIGNED <u>9-27-49</u>
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/1/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Centralia, Ill.</u>
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. <u>9-28-49</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Plonka, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Beiderwieden F.H. Inc.</u>	ADDRESS <u>1936 St. Louis Ave</u>
---	--	--	-----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

RH-50

---

---

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Heal to Paulson

Licensed Embalmer No. 4114

P. O. Address 1936 St Louis Ave

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.