

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1950

State File No. 28818  
28818  
7149

BIRTH NO. 46114-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE |  | b. COUNTY  |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN) St. Louis, Mo           |  | c. LENGTH OF STAY (in this place) 14y. 10m   |  | c. CITY (If outside corporate limits, write RURAL and give township) Jennings Mo (RURAL) |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital                                  |  | d. STREET ADDRESS 818 ARLINE.  |  |  |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) Infant Male b. (Middle) c. (Last) Woodworth  |  |  | 4. DATE OF DEATH (Month) (Day) (Year) July 24 1950 |  |  |
| 5. SEX Male   |  | 6. COLOR OR RACE white   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1                                 |  |
| 8. DATE OF BIRTH July 23-1950   |  | 9. AGE (In years last birthday) 1  |  | 10. IF UNDER 1 YEAR Months 10 Days 10  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTH PLACE (State or foreign country) 0   |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13. FATHER'S NAME Frank HARPER   |  | 13b. MOTHER'S MAIDEN NAME Woodward. Delores Rae Short |  | 14. NAME OF HUSBAND OR WIFE  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.                               |  | 17. INFORMANT'S SIGNATURE OR NAME Frank Harper Woodward ADDRESS 818 Arline |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc.* It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) unknown<br>DUE TO (c) unknown<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br>unknown |  | INTERVAL BETWEEN ONSET AND DEATH 1hr 10min |  |
|---|--|--|--|--|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION none                        |  | 19b. MAJOR FINDINGS OF OPERATION none  |  | 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) m. |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? 776x  |  |

22. I hereby certify that I attended the deceased from 7-23, 1950, to 7-24, 1950, that I last saw the deceased alive on 7-24, 1950, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

|   |  |                               |  |  |  |
|---|--|-------------------------------|--|--|--|
| 23a. SIGNATURE Kenneth W. Larsen M.D. (Degree or title) |  | 23b. ADDRESS 607 N. Grand Ave |  | 23c. DATE SIGNED 7-24-50                           |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) LAUG 23 1950  |  | 24b. DATE                     |  | 24c. NAME OF CEMETERY OR CREMATORY Anatomical Bore |  |
| 24d. LOCATION (City, town, or county) (State)           |  |                               |  |  |  |

|                                      |  |                                     |  |  |  |
|--------------------------------------|--|-------------------------------------|--|--|--|
| DATE REC'D BY LOCAL REG. AUG 23 1950 |  | REGISTRAR'S SIGNATURE J. B. Basater |  | 25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc. ADDRESS |  |
|--------------------------------------|--|-------------------------------------|--|--|--|

WRITE PLAINLY—USING 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.....

....., Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

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.**