

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40889

State File No. ....

FILED DEC 2 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10317**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>California</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Los Angeles,</b>	
		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>HENRY</b>			4. DATE OF DEATH <b>NOVEMBER 5, 1952</b>
a. (First)	b. (Middle)	c. (Last)	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 28-1869</b>
9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Centralia, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Henry Woker Sr.</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Martha Woker</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Geo. Holgreve</b> ADDRESS <b>1931a Sullivan Avenue</b>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>THROMBOSIS OF RGT. MIDDLE CEREBRAL ARTERY</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>CEREBRO-ARTERIOSCLEROSIS</b>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (a.e., 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? <b>334X</b>	
22. I hereby certify that I attended the deceased from <b>11-3-52</b> , 19___, to <b>11-5-52</b> , 19___, that I last saw the deceased alive on <b>11-5-52</b> , 19___, and that death occurred at <b>11:55Pm.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>H. G. Brown, M.D.</b> (Degree or title)		23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>11-6-52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE <b>Wed-11-12-52</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Los Angeles, California</b>
DATE REC'D BY LOCAL REG. <b>NOV 10 1952</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Beidervlieden F.H. Inc.</b> ADDRESS <b>1936 St. Louis Ave St. Louis, Missouri</b>	

(Licensed Embalmer's Statement on Reverse Side)

Utter McKinley Mortuary  
4440 Whitter Blvd.  
Los, Angeles, California

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

*Max L. Clafel*

Licensed Embalmer No.

4170

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.