

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12557**

FILED MAR 24 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2545**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2189	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 4230 West Papin Street		d. STREET ADDRESS (If rural, give location) 18 4230 West Papin Street	
3. NAME OF DECEASED (Type or Print) Alexander a. (First) Alexander b. (Middle) Wooldridge c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 3 5 53	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 8-15-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General hauling		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74 # UNDER 1 YEAR Months Days # UNDER 1 HR. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME Bettie	
14. NAME OF HUSBAND OR WIFE Lydia Wooldridge		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lydia Wooldridge 4230 W. Papin St	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio-Vascular Disease ANTECEDENT CAUSES Accident DUE TO (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 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 443X		22. I, hereby certify that I attended the deceased from 3/26/53 , to 3/5, 1953 , that I last saw the deceased alive on 3/5, 1953 and that death occurred at 7:35 a.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS [Address]	
23c. DATE SIGNED 3/5/53		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 3-9-53		24c. NAME OF CEMETERY OR CREMATORY Greenwood	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell Und., Co. 2732 Pine St.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 7 1953 [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell Und., Co. 2732 Pine St.	

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 *James A. Carter*

Licensed Embalmer No. *11081*

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.