

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20082

State File No.

FILED JUN 4 1953

318

1003

5132

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
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. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hospital				d. STREET ADDRESS (If rural, give location) 2219 2022 1/2 Biddle			
3. NAME OF DECEASED (Type or Print) a. (First) Rachel		b. (Middle)		c. (Last) Woods		4. DATE OF DEATH (Month) (Day) (Year) May 20 1953	
5. SEX FEMALE		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH Dec. 24, 1899	
9. AGE (in years last birthday) 53		10. IF UNDER 1 YEAR Months		10. IF UNDER 1 YEAR Days		10. IF UNDER 1 HR. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenwood, Miss	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE Phillip Woods				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.	
17. INFORMANT'S SIGNATURE OR NAME				ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast							
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.							
ANTECEDENT CAUSES							
DUE TO (b) Generalized Arteriosclerosis							
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 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 170X			
22. I hereby certify that I attended the deceased from 4-17 , 19 53 , to 5-20 , 19 53 , that I last saw the deceased alive on 5-20 , 19 53 , and that death occurred at 10:15pm. , from the causes and on the date stated above.							
23a. SIGNATURE Odessa E. Brooks				23b. ADDRESS M. D. 2601 N. Whittier St		23c. DATE SIGNED 5-21-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 5/25/53		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. MAY 22 1953		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE W. Robinson		ADDRESS Edison 3017 N. Market 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

Leroy W. Bannister

Licensed Embalmer No. 4523

P. O. Address 3880 Easton 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.