

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009491

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 628

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 2 1962

1. PLACE OF DEATH
 a. COUNTY ST. LOUIS
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KINLOCK Length of stay in 1b 20 YRS.
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8041 Scott Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MO b. COUNTY ST LOUIS
 c. CITY OR TOWN St Louis Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 8041 Scott Reside on Farm Yes No

3. NAME OF DECEASED First ROSE Middle ANNA Last WOODS 4. DATE OF DEATH Month 2 Day 19 Year 62

5. SEX FEMALE 6. COLOR OR RACE NEGRO 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 1-2-1905 9. AGE (last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 10b. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (City and state or country) ALICEVILLE MISS 12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME TOLLIE WILDER 13b. MOTHER'S MAIDEN NAME LOU HARRIS 14. NAME OF HUSBAND OR WIFE Rev. Odell 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. NONE 17. INFORMANT Rev. Odell Woods Address 8041 Scott

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Coronary Thromboses
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Viruses Pneumonia
 DUE TO (c) _____
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour _____ Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from 2-19-62 to 2-19-62 and last saw her alive on 2-19-62
 Death occurred at 9:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ray Johnson MD (Degree or title) 22b. ADDRESS Ferguson MO 22c. DATE SIGNED 2-21-62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 2-26-62 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK 23d. LOCATION (City, town, or county) (State) BERKLEY MO

24. FUNERAL DIRECTOR PRICE UND CO. ADDRESS 2829 Washington 25. DATE RECD. BY LOCAL REG. 2-21-62 26. REGISTRAR'S SIGNATURE John M. Murphy

VS 300 Rev. 4/59
 14028
 24028
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 4 3
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 12 90-0
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 _____
Signature of Student Embalmer

Signed Edward W. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.