MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32150

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City So Loeus (No. City Hospital St. ..... Ward)

File No. ..... Registered No. 9451

2. FULL NAME 4801 Peter Goldman

(a) Residence. No. Stag Hotel St., 25 Ward. (If nonresident give city or town and State)

(Usual place of abode) 8/9 Market St.

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Cohety

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 9 - 1848

7. AGE: Years 80 | Months 8 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT Hospital Information

(Address) E Rowan City Hospital

15. FILED ..... 19.. Max C Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1928

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1928 to Sept 21, 1928 that I last saw him alive on Sept 21, 1928, and that death occurred, on the date stated above, at 2:40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerotic gangrene of right leg - amputation

936

97B

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) General arteriosclerosis

Chr. myocarditis (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? Yes. DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H C Westerman, M. D

9/22, 1928 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Carlyle Ill

DATE OF BURIAL: 9/22 1928

20. UNDERTAKER: Southern U & T Co

ADDRESS: 7315 S. Bdway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Goldman