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

Do not use this space.

4594

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 1278

City St Louis (No. 7423 Pennsylvania Av St. ..... Ward)

2. FULL NAME Ida Frieda Goos

(a) Residence. No. ..... St., 1 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 24. 1905

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
24	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): Elder Mfg Co
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Henry W Goos
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Old Monroe
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Emma Filsinger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Old Monroe
(STATE OR COUNTRY) Missouri

14. INFORMANT Emma Goos
(Address) Old Monroe Mo

15. FILED 1 26 1929 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 24, 1929, to Jan 24, 1929, that I last saw her alive on Jan 24, 1929, and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

10 (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) B F Tate, M. D
, 19 (Address) 9439 Edgar ave

*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: Old Monroe Mo
DATE OF BURIAL: 1/28 1929

20. UNDERTAKER: C Hoffmeister U & Co
ADDRESS: 7814 S Bdwy

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.

THIS IS A PERMANENT RECORD