

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

Do not use this space.

23715

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *Barnes Hospital*)

Registration District No. *791*
Primary Registration District No. *100B*

File No.....
Registered No. *7235*
St. Ward)

2. FULL NAME *Mamie Goodin*

(a) Residence, No. *6465 Ellenwood* St., *3* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb. 14 - 1889*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 | *4* | *16*

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *House Maid*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *244*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

FATHER
13. NAME *Frank Monroe*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

MOTHER
15. MAIDEN NAME *Lucy Willis*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

17. INFORMANT (ADDRESS) *Mildred Owens, 3387 Monroe, Kirkwood Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Father Dicksons* DATE *July 2* 19*31*

19. UNDERTAKER (ADDRESS) *Louis H. Bopp, Kirkwood*

20. FILED *30* 19*31* *Max C. Parker* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 30, 1931*

22. I HEREBY CERTIFY, That I attended deceased from *6-28*, 19*31*, to *6-30*, 19*31*. I last saw her alive on *6-30*, 19*31*. Death is said to have occurred on the date stated above, at *9:14 a.m.*

The principal cause of death and related causes of importance were as follows:
Date of onset

Heat Prostration
540
7396
191
Other contributory causes of importance
Hysterectomy for
multiple removal of
uterus - not subsequent

Name of operation *Hysterectomy* Date of *6/30/31*

What test confirmed diagnosis? *Positive* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *No* Date of injury..... 19.....
Where did injury occur? *No*
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *suicide*

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *John B. O'Neill*, M. D.
(Address) *600 S. Kings Highway*

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

