

REC'D OCT 21 1938

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

32527  
Do not use this space.

1. PLACE OF DEATH *Jefferson* *1* Registration District No. *420*  
 (a) County *Jefferson* *1* (b) Township *Walle* Primary Registration District No. *5574*  
 (c) City *Victoria* (d) Street No. \_\_\_\_\_ Registered No. *68*  
 (e) Length of residence in city or town where death occurred *21* yrs. *0* mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.  
 2. PRINT FULL NAME *Sigmund GOLDMAN* *H 35*  
 (a) Residence, No. *Victoria mo.* St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *Mary R. Goldman*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 14 - 1878*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*59 10 7*  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Truckman*  
 9. Industry or business in which work was done, as saw mill, bank, etc. *Self*  
 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) *Greenway Germany*  
 FATHER 13. NAME *Fred Goldman*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Greenway Germany*  
 MOTHER 15. MAIDEN NAME *Adel (Goldman)*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *France*  
 17. INFORMANT (ADDRESS) *Mrs. Mary R. Goldman Victoria mo.*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *De Soto, mo* DATE *9/24* 1938  
 19. FUNERAL DIRECTOR (ADDRESS) *Daniel J. Mahu De Soto, mo.*  
 20. FILED *9-30* 1938 *Jeneva Danell* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-21* 1938  
 22. I HEREBY CERTIFY, That I attended deceased from *9-18*, 1938, to *9-21*, 1938.  
 I last saw him alive on *9-21*, 1938. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
*Cancer of Digestive Tract*  
 Date of onset *5*  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *no*  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? *no*  
 If so, specify *Chas. C. Sato* M. D.  
 (Signed) *Chas. C. Sato* M. D.  
 (Address) *De Soto, mo.*  
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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.

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STATEMENT BY LICENSED EMBALMER

I, Daniel J. Mohr, Licensed Embalmer No. 3783

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Daniel J. Mohr

Missouri L. E.

No. 3783 or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision:

Signed Daniel J. Mohr

Licensed Embalmer No. 3783

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.)

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

325-27

Do not use this space.

1. PLACE OF DEATH

(a) County Jefferson Registration District No. 420  
 (b) Township Waller Primary Registration District No. 5574  
 (c) City ..... (d) Street No. .... St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. ....

2. PRINT FULL NAME Sigmund Goldman

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/21 1938

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said

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

I last saw h. .... alive on ....., 19... Death is said to have occurred on the date stated above, at ..... m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min. 39 10 7

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

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

Capitulum of Digestive Date of onset  
Primary rectal  
indiverted

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

Other contributory causes of importance: 53

FATHER 13. NAME

Name of operation ..... Date of .....

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

What test confirmed diagnosis? ..... Was there an autopsy? .....

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

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

Where did injury occur? ..... (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury .....

PLACE DATE 19

Nature of injury .....

19. FUNERAL DIRECTOR (ADDRESS)

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

20. FILED 19

If so, specify

(Signed) Chas E. Fallis, M. D.

(Address) Desoto mo

Local Registrar.

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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