

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.

23 1939

REC'D MAR 9 1939

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

7859  
Do not use this space.

1. PLACE OF DEATH

(a) County ST. LOUIS Registration District No. 784  
(b) Township ST. FERDINAND Primary Registration District No. 200  
(c) City VIGOR (d) Street No. \_\_\_\_\_  
(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. 323

2. PRINT FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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) Feb. 18-1939  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
3  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil  
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 \_\_\_\_\_

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

13. NAME Ernest Goode

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gasconade Co MO

15. MAIDEN NAME Violet Exenaina

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

17. INFORMANT Ernest Goode (ADDRESS) Vigors MO

18. BURIAL, CREMATION, OR REMOVAL PLACE Lee Lee Cem. DATE 2/23 1939

19. FUNERAL DIRECTOR Baumgardner Bros Inc (ADDRESS) 2504 Woodson Rd Overland

20. FILED DR Meyer M.D. Registrar Local Registrar.

FEB 23 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 21 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1939 to Feb. 21 1939  
I last saw him alive on Feb. 20 1939. Death is said to have occurred on the date stated above, at 7:00 m.  
The principal cause of death and related causes of importance were as follows:

Valvular Disease of the Heart  
Date of onset 2-18-39

Other contributory causes of importance: 1570

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Ch. necr. 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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) H. G. Hoffman, M. D.

(Address) P. O. Box 111, Mo

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

\_\_\_\_\_ L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

*Oscar J. Mueller*

Licensed Embalmer No. 3039

**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.)**