

S. No. 2  
M-4-13-40  
Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 14-33

Registration District No. H/5 Primary Registration District No. 5580

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Worcester Springs, Mo.

1. PLACE OF DEATH:  
(a) County JEFFERSON  
(b) City or town RURAL - MERAMEC MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ST. JOSEPH'S HILL INFIRMARY  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 MONTHS - 20 DAYS  
(Specify whether  
In this community 30 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County ST. LOUIS  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3726 DELOR AVE.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME FRANK A. GOOD 3M  
3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 31  
year 1940 hour 2 minute 05 P.M.  
21. I hereby certify that I attended the deceased from October 13, 1939, to July 31, 1940  
that I last saw him alive on July 31, 1940  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife KATHERINE 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased NOV 24 1862  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
77 8 7 hr. \_\_\_\_\_ min.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

9. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)  
10. Usual occupation LABORER - RETIRED

11. Industry or business \_\_\_\_\_  
12. Name FRANK A GOOD 7  
13. Birthplace SWITZERLAND 7  
(City, town, or county) (State or foreign country)  
14. Maiden name ANN MARRIE MEHLE  
15. Birthplace SWITZERLAND 7  
(City, town, or county) (State or foreign country)

16. (a) Informant Brother's Rock  
(b) Address St. Joseph's Hill Infirmary  
17. (a) Rural (b) Date thereof 18/3/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Peter & Paul  
18. (a) Signature of funeral director Wacker-Welderle  
(b) Address 2331 Broadway  
19. (a) Blvd 1940 (b) James A Townsend  
(Date received local register) (Registrar's signature)

23. Signature James S Sargent (M. D. or other) \_\_\_\_\_  
Address Worcester Springs Mo. Date signed 7/31/40

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Robert C. White* .....

Licensed Embalmer No..... *2128* .....

P. O. Address..... *St Louis Mo.* .....

**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.)**

**If this body is not embalmed, fact should be so stated above.**