

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 37003
Registrar's No. 9276

Registration District No. 791

Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 1 mo 2 das
(Specify whether years, months or days)

In this community 50 years

3. (a) PRINT FULL NAME Albert Goodloe
 3. (b) If veteran, name war _____ 3. (c) Social Security No. unk

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced. Widowed
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased unk
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
abt 80 hr. _____ min.

9. Birthplace unk 9
(City, town, or county) (State or foreign country)
 10. Usual occupation unk 9
 11. Industry or business unk
 MOTHER FATHER { 12. Name unk 9
 13. Birthplace unk 9
(City, town, or county) (State or foreign country)
 14. Maiden name unk
 15. Birthplace unk
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Shorty Johnson
 (b) Address 3412 Pine St
 17. (a) Burial (b) Date thereof 11.12.40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park
 18. (a) Signature of funeral director English Under
 (b) Address 2931 Leape ave
 19. (a) NOV 12 1940 (b) J. W. Johnson
(Date received local Registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis 21
(If outside city or town limits, write "RURAL")
 (d) Street No. 3412 Pine
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November, 1940 year. 8:05 hour. 9 minute. A.M.

21. I hereby certify that I attended the deceased from October 8, 1940, to November 9, 1940, that I last saw him alive on November 9, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death
Arteriosclerotic Heart Disease c
Coronary Sclerosis

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: AD
 Of operations _____
 Of autopsy _____

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? _____
(Specify type of place) (e) Means of injury
 While at work? _____
 23. Signature J. W. Johnson (M. D. or other) _____
 Address 2601 N Whittier Date signed _____

Duration
Unknown
 PHYSICIAN
 Underline the cause to which death should be charged statistically

FORM 5-17-39
 REV. 5-17-39
 U. S. G. P. 1 X19511

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 Louis V. Atkins

Licensed Embalmer No. 2842

P. O. Address 3644 Finneya

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, above space should be left blank.