

No. 2
1-4-41
-17-39
X28390

Registration District No. **791** Primary Registration District No. _____

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: **Jewish Hospital *Exonite 3***
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Brunetta Goorman**

3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **Female** **5. Color or race** **White**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Charles Goorman** **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased **March 31 1877**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	1	16	hr. _____ min. _____

9. Birthplace **St. Louis, Mo** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER

12. Name **Unknown Roman**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Max Goorman**
(b) Address **711 Heman Ave.**

17. (a) Burial **(b) Date thereof** **6-19-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Sinai Cemetary**

18. (a) Signature of funeral director: *Herman Friedberg*
(b) Address **5216 Delmar Blvd.**

19. (a) JUN 17 1941 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **5011 Page Ave.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **16**
year **1941** hour **11** minute **PM**

21. I hereby certify that I attended the deceased from **Feb 4**
12 19**35** to **June 16** 19**41**
that I last saw her alive on **June 16** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic lymphatic Leukemia** **1 year**
Duration _____

Due to _____

Due to _____

Other conditions **✓**
(Include pregnancy within 3 months of death)

Major findings: **✓**
Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 _____

23. Signature: **Harold Schiff** (M. D. or other) **0**
Address: **703 University Club Bldg.** Date signed **6/17/41**

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

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 *Chas. W. Cooper*

Licensed Embalmer No. *3830*

P. O. Address *5216 Delma*

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.