

S. No. 2  
M-5-42  
v. 5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41915  
State File No. \_\_\_\_\_

FILED JAN 15 1943  
Registration District No. \_\_\_\_\_

Primary Registration District No. 200

Registrar's No. 2704

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town LEMA  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mt. St. Rose Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Mo  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 3327 So. 9th St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Goad, Gladys

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19  
year 1942 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to Dec 19 1942  
that I last saw her alive on Dec 16 1942  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife FELIS GOAD

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased OCT - 27 - 1908  
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tbc Duration 5 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Tbc Laryngitis, Oromaxillary Fistele bilat, 6 wk  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

34	1	22	hr. _____ min.
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Major findings: Post partum 2 mos

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace BLAKWELL MO  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business HOME

MOTHER { 12. Name WILLIAM WATERS

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

14. Maiden name ELIZABETH BOYER

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

16. (a) Informant Felis Goad

(b) Address 3327 S. 9th St.

17. (a) BURIAL (b) Date thereof 12-22-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Buller Kelly

(b) Address 1416 N. Taylor ave

19. (a) DEC 21 1942 (b) C. G. McRaman  
(Date received local registrar) (Registrar's signature)

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) Means of injury \_\_\_\_\_

23. Signature W. Webb (M. D. or other) \_\_\_\_\_

Address 4500 Olive St. St. Louis Mo Date signed 12-20-42

**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 *Clement McNeary*.....

Licensed Embalmer No. *3732*.....

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

**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.**