

No. 2  
5-42  
5-17-43  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 1998

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

FILED MAR 15 1943 318  
Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
In this community 30 years (Specify whether 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. 809 N. Jefferson (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME George Goody

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
Unknown — About 53 hr. min.

9. Birthplace: Texas (City, town, or county) (State or foreign country)

10. Usual occupation: Porter

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name: Shedrick Goody

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

14. Maiden name: Unknown

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

16. (a) Informant: Shirley M. Smith

(b) Address: 2601 N. Whittier

17. (a) Place: burial or cremation: Washington D.C. (b) Date thereof: 2-15-43 (Month) (Day) (Year)

18. (a) Signature of funeral director: \_\_\_\_\_ (b) Address: 3550 Patton St

19. (a) (Date received local registrar) MAR 1 1943 (b) Registrar's signature: J. J. Buback

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 7, day year 1943 hour 9 minute 00 P. M.

21. I hereby certify that I attended the deceased from January 25, 19 43 to February 7, 19 43  
that I last saw him alive on February 7, 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Heart Disease Unk.  
Auricular Fibrillation Unk.

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
Unk.  
Unk.  
PHYSICIAN  
Underline the cause to which death as 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: S. E. Smith (M. D.)  
Address: 2601 Whittier Date signed: 2/11/43

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**