

**FILED MAY 31 1943**

Registration District No. 37 1943

Primary Registration District No. 6075

Registrar's No. 259

1. PLACE OF DEATH:  
(a) County St. Francois  
(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 yrs. 11 mos. 1  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 44 Hillvale  
(If rural, give location)  
(e) Citizen of foreign country? Unknown (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LILLIAN GOLDBERG

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month April day 24  
year 1943 hour 4 minute 30 P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

21. I hereby certify that I attended the deceased from Nov. 23, 1942 19\_\_\_\_ to April 24, 1943 19\_\_\_\_; that I last saw her alive on April 24, 1943 19\_\_\_\_; and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Myron Goldberg 6. (c) Age of husband or wife if alive Unk. years

Immediate cause of death Carcinomatosis Duration 1 year

7. Birth date of deceased April 11, 1881  
(Month) (Day) (Year)

8. AGE: Years 62 Months 0 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to metastatic carcinoma, left breast primary 3 yrs

9. Birthplace Liverpool, England  
(City, town, or county) (State or foreign country)

Due to Psychosis with cerebral arteriosclerosis 5 yrs

10. Usual occupation House wife

Other conditions Psychosis with cerebral arteriosclerosis  
(Include pregnancy within 3 months of death)

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

Major findings: 50  
Of operations \_\_\_\_\_

12. Name Isaac Silverstone

Of autopsy none performed  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

14. Maiden name Mary

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 4-27-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Sinai

18. (a) Signature of funeral director Albert Hoppe, Inc.

(b) Address St. Louis, Mo.

19. (a) April 30, 1943 (b) Byrdie Buchmester  
(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)  
(c) Means of injury \_\_\_\_\_  
23. Signature Paul J. Schuler (M. D. or other) MD  
Address Farmington, Mo. Date signed 4-27-43

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

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RECEIVED

District Health Officer No. 4  
District File Number 543-2125  
Date Filed 5-5-43

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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. 4084

P. O. Address Turnington

**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.**