

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16929

BIRTH NO. _____ REG. DIST. NO. 305 PRIMARY REG. DIST. NO. 6047 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY St Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Charles	
b. CITY (If outside corporate limits, write RURAL and give township) Foristell		c. LENGTH OF STAY (in this place) Foristell	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) Rachel	(First)	b. (Middle)	c. (Last) Good	4. DATE OF DEATH (Month) 4 (Day) 20 (Year) 49
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, OR DECEASED (Specify) Married	8. DATE OF BIRTH April 21 1866	9. AGE (in years, last birthday) 82	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Clark Co Ill	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Jessie Craig	13b. MOTHER'S MAIDEN NAME Mary Miller	14. NAME OF HUSBAND OR WIFE William Good
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Howard Good	ADDRESS 615 W Pearson Mexico Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 1/2 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			331X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1946, to April, 1949, that I last saw the deceased alive on April 20, 1949, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Raymond H. Lugin M.D.	(Degree or title)	23b. ADDRESS Wright City, Mo.	23c. DATE SIGNED 4-21-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-22-49	24c. NAME OF CEMETERY OR CREMATORY Wright City Cem	24d. LOCATION (City, town, or county) (State) Wright City Mo
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DATE REC'D BY LOCAL REG. 4/30/49	REGISTRAR'S SIGNATURE Mark P. Lugin	25. FUNERAL DIRECTOR'S SIGNATURE Nieburg Furn & Und Co	ADDRESS Wright City Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer NO. 9

District File Number

Date Filed MAY 14 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Julius J. Dieburg

Licensed Embalmer No. 33066

P. O. Address Wright City Mo

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.