

FILED SEP 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 28866

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

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>2034</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>NORMANDY</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		17a _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>PENN NURSING Home</u>				d. STREET ADDRESS (If rural, give location) <u>1102 DOLMAN ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hugh</u>		b. (Middle) _____		c. (Last) <u>GOODWIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG 22-1949</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>JUNE 20-1876</u>	
9. AGE (In years last birthday) <u>74 YRS</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KATY K. R.</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>ISABELLE UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. John Goodwin 1102 Dolman</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>				<u>1 day</u>	
		ANTECEDENT CAUSES					
		*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				<u>5 years</u>	
		DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u>				<u>4 1/2</u>	
		DUE TO (c) _____				<u>1 year</u>	
		II. OTHER SIGNIFICANT CONDITIONS <u>Spinal Cord degeneration on arteriosclerotic bases</u>					
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <u>July 12, 1949</u> , to <u>Aug 22, 1949</u> , that I last saw the deceased alive on <u>Aug 5, 1949</u> , and that death occurred at <u>7 A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Lewis Littmann M.D.</u>				23b. ADDRESS <u>8231 Clayton Rd.</u>		23c. DATE SIGNED <u>8/23/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG-25-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>	
DATE REC'D BY LOCAL REG. <u>8-23-49</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Alonke, M.D.</u>		FURNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Schner 3125 Lafayette Av</u>			

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

*Joe B. Vollmer*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Poppy Ave*

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.