

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42512**  
Registrar's No. **16704**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1001</b>		Registrar's No. _____						
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____								
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		d. ADDRESS (If rural, give location) <b>24<sup>th</sup> 3727 Iowa Ave</b>						
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3727 Iowa Ave</b>				3. NAME OF DECEASED a. (First) <b>Marie</b> (Type or Print) b. (Middle) _____ c. (Last) <b>Good</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>12-12-1949</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>3-20-1862</b>		9. AGE (In years last birthday) <b>87</b> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>*****</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Louise Sullivan</b> ADDRESS <b>3727 Iowa Ave</b>							
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Distention</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Bronchitis</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 D</b> <b>5 D</b>				
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) <b>10th Mo</b>		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? <b>56th X</b>	
22. I hereby certify that I attended the deceased from <b>June, 1938</b> , to <b>Dec., 1949</b> , that I last saw the deceased alive on <b>12-12, 1949</b> , and that death occurred at <b>7:30 AM</b> from the causes and on the date stated above.												
23a. SIGNATURE (Degree or title) <b>D. J. Johnson M.D.</b>				23b. ADDRESS <b>6400 Morganford</b>				23c. DATE SIGNED <b>12-12-49</b>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12-14-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Picker Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>7133 Gravois Ave. Mo</b>						
DATE REC'D BY LOCAL REG. <b>DEC 17 1949</b>		REGISTRAR'S SIGNATURE <b>D. B. Foster</b>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ziegenhain Bros 6409 Gravois Ave</b>						

(Licensed Embalmer's Statement on Reverse Side)

2 to 4  
 Dr. Johnson  
 HU 4016  
 Morganford and Holly Hills  
 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.

Signed.....

*Henry M. Brammer*

Signed.....  
Student Embalmer

..... Licensed Embalmer No. *4200*

..... 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.**