

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10475

State File No. 2277

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

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

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>JEFF.</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis - Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>DE SOTO Mo. 0502</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>218 MINERAL</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frances May</u> b. (Middle) _____ c. (Last) <u>Goodnight</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 9 1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 10 1873-76</u>
9. AGE (In years at birthday) Months Days Hours Min. <u>76 2 5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Knobnoster Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>GEO. GALLAHER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY (UNKNOWN)</u>	
14. NAME OF HUSBAND OR WIFE <u>CHAS GOODNIGHT</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>NONE</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>CHAS G. GOODNIGHT</u>		ADDRESS <u>DESOTO Mo</u>	
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) <u>Pulmonary Embolus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <u>Complete Abdominal Myelomeningocele</u> DUE TO (c) <u>of Cancer of the Uterus</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>2 March 50</u>		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) <u>172X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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>27 Feb</u> , 19 <u>50</u> , to <u>9 March</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>9 March</u> , 19 <u>50</u> , and that death occurred at <u>6:41 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>M. C. ... M.D.</u>		23b. ADDRESS <u>605 Fair Oaks St. ...</u>	
23c. DATE SIGNED <u>9 March 50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>MAR, 12</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Knobnoster</u>		24d. LOCATION (City, town, or county) (State) <u>Knobnoster Mo.</u>	
DATE REC'D BY LOCAL REG. <u>MAR 9</u>		REGISTRAR'S SIGNATURE <u>J. B. ...</u>	
25. FEDERAL DIRECTOR'S SIGNATURE <u>Donnell B. ...</u>		ADDRESS <u>...</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 _____

Percy Melater

Student Embalmer No. *3468*

working under my personal supervision

Percy Melater
Student Embalmer No. *300*

Signed *Samuel B. Dietrich*

Licensed Embalmer No. *4104*

P. O. Address *Delto no*

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.