

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

34834
8275

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE St. Louis Mo. b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo.		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) 2067		OR TOWN _____			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hosp. 5400 Arsenal St.				d. STREET ADDRESS (If rural, give location) Formerly of 4922 Maffitt Ave					
3. NAME OF DECEASED (Type or Print)			a. (First) ARTHUR			b. (Middle) _____			
			c. (Last) GOOD			4. DATE OF DEATH (Month) (Day) (Year) Sept. 30, 1950			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Feb. 12 1883			
9. AGE (In years less birthday) 67		IF UNDER 1 YEAR Months 7		IF UNDER 1 YEAR Days 18		IF UNDER 24 HRS. Hours Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (State or foreign country) Illinois			
12. CITIZEN OF WHAT COUNTRY? _____			13a. FATHER'S NAME Henry Good			13b. MOTHER'S MAIDEN NAME Rose Keown			
14. NAME OF HUSBAND OR WIFE Annabelle Johnston			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. _____			
17. INFORMANT'S SIGNATURE OR NAME Mrs Mary Merkle			ADDRESS 4605 Newport.						
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) Broncho-pneumonia				INTERVAL BETWEEN ONSET AND DEATH 3 ds.	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Paresis				1949x	
				DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS 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? 0215X					
22. I hereby certify that I attended the deceased from Oct. 3, 1949 , to Sept. 30, 1950 , that I last saw the deceased alive on Sept 30, 1950 , and that death occurred at 9:35 p.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Anna M. Merkle M.D.				23b. ADDRESS 5400 Arsenal St.			23c. DATE SIGNED 10/1/50		
24a. BURIAL, CREMATION (Specify) Burial		24b. DATE 10/3/50		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. OCT 2 1950		REGISTRAR'S SIGNATURE J. B. Sabater			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Fun. Dir. 2849 N. Euclid				

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Charles W. D. [Signature]*
Student Embalmer No.
Licensed Embalmer No. *4379*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.