

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No.

3145

FILED FEB 3 1953

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 0630	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				d. STREET ADDRESS (If rural, give location) 2 / 1802 Cole Street			
3. NAME OF DECEASED (Type or Print) SARAH		a. (First)		b. (Middle)		c. (Last) GOODWOLT	
4. DATE OF DEATH JANUARY 10, 1953		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Sept. 2, 1892		9. AGE (In years last birthday) 60		10. MONTHS 4		11. DAYS 4	
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 (City and State or Foreign Country) England		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Jesse Wilkinson		13b. MOTHER'S MAIDEN NAME Nellie Patterson		14. NAME OF HUSBAND OR WIFE Robert Goodwolt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Hospital Record			
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) Acute left Ventricular failure ANTECEDENT CAUSES DUE TO (b) Coronary Artery Disease DUE TO (c) Diabetes mellitus & atherosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ? Strangulated hernia				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☒	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? 260X			
22. I hereby certify that I attended the deceased from 1-9-53 , 19 53 , to 1-10-53 , 19 53 , that I last saw the deceased alive on 1-10-53 , 19 53 , and that death occurred at 9:15P m., from the causes and on the date stated above.							
23a. SIGNATURE Albert Edward Stok MO (Degree or title)				23b. ADDRESS 1515 LAFAYETTE AVENUE		23c. DATE SIGNED 1-12-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1-31-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JAN 20 1953		REGISTRAR'S SIGNATURE Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service			

(Licensed Embalmer's Statement to be Reviewed by)

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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.