

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 38773
9339

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 Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings 4138		d. STREET ADDRESS (If rural, give location) 7528 W. Florissant Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital							
3. NAME OF DECEASED (Type or Print) a. (First) Hazel Ann Good b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) Oct. 12th, 1954				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1908 Oct. 15, 1908	9. AGE (in years) (If under 1 year, last birthday) (Months) (Days) (Hours) (Mins.) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Buyer		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Buyer		10b. KIND OF BUSINESS OR INDUSTRY Famous-Barr		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? 0	
13a. FATHER'S NAME Wm. J. Good		13b. MOTHER'S MAIDEN NAME Jesse F. Smith		14. NAME OF HUSBAND OR WIFE None.			
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. 493-07-7207		17. INFORMANT'S SIGNATURE OR NAME . ADDRESS Mrs. Ora Myers 7528 W. Florissant			
18. CAUSE OF DEATH (Give only one cause per line for (a), (b), and (c)) <i>This does not mean the mode of dying, such as asphyxiation, asphyxia, etc., it means the disease, injury, or complication which caused death.</i>		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General Carcinomatosis ANTECEDENT CAUSES Delator Cancer of Ovary Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) By contact DUE TO (c) Cancer of Sigmoid II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Causing Obstruction of Bowel				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 1) Cancer of Ovaries. 2) Cancer of Sigmoid 3) Obstruction of Bowel				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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 15 3X			
22. I hereby certify that I attended the deceased from Jan 22, 1953 , to Oct. 12, 1954 , that I last saw the deceased alive on Oct 12, 1954 , and that death occurred at 7:10 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Walter C. Kirschner M.D.				23b. ADDRESS 508 N. Grand Blvd		23c. DATE SIGNED 10/14/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 15th		24c. NAME OF CEMETERY OR CREMATORY valhalla		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. OCT 14 1954		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kraeger Funeral Directors 3402 N. King Highway			

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Elmo R. Sadwell

Licensed Embalmer No. 4077

P. O. Address St. Louis, Mo.

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.