

FILED JUL 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24734

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 1511

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KIRKWOOD
c. LENGTH OF STAY (In this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION ST JOSEPH HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO. b. COUNTY ST LOUIS
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KIRKWOOD 4683
d. STREET ADDRESS (If rural, give location) 655 SIMMONS AVE

3. NAME OF DECEASED (Type or Print)
a. (First) KATHRYN b. (Middle) T c. (Last) GOODWIN
4. DATE OF DEATH (Month) (Day) (Year) 7 2 55

5. SEX F 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W 8. DATE OF BIRTH 8-6-1869 9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months 10 IF UNDER 6 HRS. Days 8 Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (State or foreign country) BURLINGTON VERMONT 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME JEREMIAH NOONAN 13b. MOTHER'S MAIDEN NAME MARGARET O'LEARY 14. NAME OF HUSBAND OR WIFE FRANK E. GOODWIN

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. NONE 17. INFORMANT'S SIGNATURE OR NAME ADDRESS AM AIMEE KIEFER 655 SIMMONS AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
18. MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis
DUE TO (c) Senility
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Interval between ONSET AND DEATH 4 weeks
2 yrs.
3 yrs.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION 331X 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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 5-1, 1936, to 7/2, 1955, that I last saw the deceased alive on 7-1, 1955, and that death occurred at 5 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. Thesleim 23b. ADDRESS Kirkwood, Mo. 23c. DATE SIGNED 7/2/55

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 7 5 1955 24c. NAME OF CEMETERY OR CREMATORY ST PETERS 24d. LOCATION (City, town, or county) (State) KIRKWOOD MO

DATE REC'D BY LOCAL REG. 7/3/55 REGISTRAR'S SIGNATURE Herbert R. Donke, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Louis H. Bopp Inc. 78

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 _____

Ben G. Goldman

Licensed Embalmer No. *366*

P. O. Address. *Fluores,*

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.