

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011672

STATE FILE NUMBER
2592

FILED MAR 19 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN ILLINOIS GRANITE CITY	
c. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) RR#1 Box 210	

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM FREDERICK GOODMAN			4. DATE OF DEATH Month Day Year MARCH 3, 1958			
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 13, 1910	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY ENG. DEPOT	11. BIRTHPLACE (City and state or country) GREENVILLE, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME WILLIAM L. GOODMAN	13b. MOTHER'S MAIDEN NAME SARAH DEERING	14. NAME OF HUSBAND OR WIFE
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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. UNKNOWN	17. INFORMANT Lloyd Goodman Address RR#1 Box 210 Granite City, Ill
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c)
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20e. PLACE OF INJURY (e.g., farm, factory, street, office-bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office-bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Death occurred at FEB. 25, 1958 7:50 A.M.	and last saw her alive on MARCH 3, 1958
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22a. SIGNATURE C. Vermillion, M.D.	22b. ADDRESSATORY BARNES HOSPITAL	22c. DATE SIGNED 3/3/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3/3/58	23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI
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24. FUNERAL DIRECTOR Frank Mercer	ADDRESS Granite City, Ill	25. DATE RECD. BY LOCAL REG. MAR 4 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.
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300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed *Charles E. Mercer*

Licensed Embalmer No. *2985*
P. O. Address *Grant City, Md.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.