

Health,
& Welfare
Public
Service

FILED MAY 1 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017124

STATE FILE NUMBER

Registration District No. 366

Primary Registration District No. 6244

Registrar's No. 37

5. 300
1-57

09

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

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Washington</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Union</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>1109</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 mi W Old Mines</u> Length of stay in lb <u>11 yrs.</u> | | d. STREET ADDRESS (If outside, give location) <u>2 mi W Old Mines</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William Robert Goodman</u> | | | 4. DATE OF DEATH Month Day Year <u>April 25-1958</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 14 1883</u> |
| 9. AGE (In years last birthday) <u>71</u> | | FUNDER 1 YEAR Month Days <u>11 11</u> | IF UNDER 24 HRS. Hours Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RR car carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RR</u> | 11. BIRTH PLACE (City and state or country) <u>Parsons Tenn.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>William R. Goodman</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Edita Goodman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>488-12-7533</u> | 17. INFORMANT Address <u>Betty J. Farrar St. Louis mo.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last, DUE TO (b) <u>Rayonite Trailer</u> DUE TO (c) <u>Cranial thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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.) | |
| 20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>9:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Dr. M. S. Sandoz</u> | | 22b. ADDRESS <u>211 E. High St. Paris mo.</u> | 22c. DATE SIGNED <u>4/28/58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4-28-58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. mo.</u> |
| 24. FUNERAL DIRECTOR <u>Mrs. Luther Sparker</u> ADDRESS <u>Peters mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>4/28/58</u> | 26. REGISTRAR'S SIGNATURE <u>Herbert Swdall</u> | |

(Licensed Embalmer's Statement on Reverse Side)

1958
MAY 6

MS
AUG 15 1958

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 *Murphy L. Spahr*

Licensed Embalmer No. *4236*

P. O. Address *Flat River*

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.