Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041619
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11161

1. PLACE OF DEATH
a. COUNTY: Saint Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Saint Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 0 / 1121 N.7th St. Apt. 207 — Length of stay in hospital: #

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN: Saint Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1121 N.7th St.Apt.207 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: — Last: Goode

4. DATE OF DEATH: Month November Day 16 Year 1958

5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: Sept. 7, 1901
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months 4 Days 9 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Lake Village, Arkansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: James Hands
13b. MOTHER'S MAIDEN NAME: Annie Maines
14. NAME OF HUSBAND OR WIFE: Luther Goode

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mozell Hands — Address: 1121 N. 7th Street Apt.#207

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chematic Heart disease	4 yrs
DUE TO (c)	Multiple Chronic Rheumatoid Arthritis	5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 416X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1950 to Nov 15, 1958 and last saw her/him alive on Nov 15, 1958
Death occurred at 8:30 a.m. 11/16/58 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: S E Moore MD (Degree or title)
22b. ADDRESS: 2330 S. Franklin
22c. DATE SIGNED: 11-18-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-20-1958
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Dermott, Arkansas

24. FUNERAL DIRECTOR: E. B. Krouch — ADDRESS: 1221 N. Grand
25. DATE RECD. BY LOCAL REG.: NOV 19 58
26. REGISTRAR'S SIGNATURE: J. Earl Smith MD M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 [illegible]

Licensed Embalmer No. 3962

P. O. Address 1221 N. Grand

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.