Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002983 STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 366

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Mo.. St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) HomerPhillips Hosp. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2119 3636 Page — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Dover	Middle: C.	Last: Goodrich	4. DATE OF DEATH Month 1- Day 8- Year 59
5. SEX M 2	6. COLOR OR RACE Col.	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐	8. DATE OF BIRTH 3-8-1882
9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret. Pullman Porter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Howard County, Mo. 0	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Jim Goodrich	13b. MOTHER'S MAIDEN NAME Jane Shelby	14. NAME OF HUSBAND OR WIFE	
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 Lorene Henderson- Address 2450 Highland K.C. Mo.	

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) Gangrene of Foot

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arterio sclerosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 450.1

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 _____, to _____ and last saw her/him alive on _____

Death occurred at 1140 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick E. Taylor Coroner	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 1.12.59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-14-59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
24. FUNERAL DIRECTOR ADDRESS A. L. Beal Und.-4303 Delmar	25. DATE RECD. BY LOCAL REG. JAN 12'59	26. REGISTRAR'S SIGNATURE Earl Smith Mo MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.