

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026690

FILED JUL 17 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6349** STATE FILE NUMBER

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 <b>St. Louis, Mo.</b>		a. STATE <b>Missouri</b> b. COUNTY	
Length of stay in 1b <b>Unknown</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Masonic Home of Missouri Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>3621 Juniata</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>N.M.I.</b> Last <b>Goodman</b>			4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1870</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cigar maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>		11. BIRTHPLACE (City and state or country) <b>Nashville, Tenn</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Jake Goodman</b>		13b. MOTHER'S MAIDEN NAME <b>Ray Collet</b>		14. NAME OF HUSBAND OR WIFE <b>Josie Becker Goodman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>495-22-8787</b>		17. INFORMANT <b>Masonic Home of Missouri</b> <b>Lewis C. Robertson, Sup't.</b>		

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) <b>Bronchopneumonia</b> )			<b>1 week</b>
DUE TO (b) <b>Fracture of left femur due to fall 6/18/59</b>			<b>3 weeks</b>
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.) <b>Fell in his room 6/18/59 sustaining fracture of left femur</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>6/18/59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>In his room 122</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>St. Louis, Mo. Masonic Home of Missouri, 5351 Delmar</b>	

21. I attended the deceased from **January 1955** to **July 1959** and last saw her alive on **July 3, 1959**  
Death occurred at **5:40 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Harold E. Walter M.D.</b>		22b. ADDRESS <b>3720 Washington St. Louis Mo.</b>		22c. DATE SIGNED <b>7-4-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>7-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mo. Crematory</b>	23d. LOCATION (City, town, or County) (State) <b>St. Louis Missouri</b>	
24. FUNERAL DIRECTOR <b>J.B. SMITH</b> ADDRESS <b>MAPLEWOOD, Mo</b>		25. DATE REG. BY LOCAL REG. <b>JUL 6 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjb*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*J. Allen Davis*

Licensed Embalmer No. 4053

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.