MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-011939
STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 612

FILED VS MAR 14 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Length of stay in 1b: 2 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COUNTY HOSP — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Overland — Inside Limits: Yes # No ☐
d. STREET ADDRESS (If outside, give location) 2285 Ashby Rd. — Reside on Farm: Yes ☐ No #

3. NAME OF DECEASED (Type or print): First CARRIE Middle F. Last GOODNER
4. DATE OF DEATH: Month MARCH Day 3, Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married # Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5)13)1904
9. AGE (last birthday): 56
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (City and state or country): Hillsville Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Reed Hall
13b. MOTHER'S MAIDEN NAME: Rachel Goad
14. NAME OF HUSBAND OR WIFE: James Goodner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
17. INFORMANT: James Goodner Address: 2285 Ashby Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia - Anuria
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bilateral Necrotizing Pyelonephritis ?
DUE TO (c) Bilateral pelvic and ureteral calculi
INTERVAL BETWEEN ONSET AND DEATH ?
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 March 1, 1961, to March 3, 1961 and last saw her/him alive on March 3, 1961
Death occurred at 7 30 A.m on the date stated above, and to the best of my knowledge, from the causes stated.
22. SIGNATURE Albert L. Howe (Degree or title) M.D.
22b. ADDRESS 601 S. BRENTWOOD Bl.
22c. DATE SIGNED 3/3/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE 3)6)1961
23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery
23d. LOCATION (City, town, or county) St. Louis County, Mo. (State)
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG. 3-4-61
26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

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_____ Signed Sheldon Collier

Signature of Student Embalmer

Licensed Embalmer No. 3382

P. O. Address St. Ann. M

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.