

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028675
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7118**

FILED JUL 31 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1
2 *22-29*
3
4 *1*
5 *2*
6
7 *1*
8 *2*
9
10
11
12 *75-3*
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 60 yrs | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 814 Hickory Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Margaret Goodman | | | 4. DATE OF DEATH Month Day Year July 16 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-23-1884 |
| 9. AGE (last birthday) 78 | | 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) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Indiana |
| 12. CITIZEN OF WHAT COUNTRY U. S. A. | | 13a. FATHER'S NAME Unknown | |
| 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Thomas Goodman (deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Henry R. Goodman Address 821 Hickory |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO (b) Generalized Arterio Sclerosis DUE TO (c) 4200 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | 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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 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.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 _____ 8:5 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Paul J. Simon</i> (Degree & Title) <i>Deputy Coroner</i> | | 22b. ADDRESS 1308 Clark | 22c. DATE SIGNED 7/19/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7-20-62 | 23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
| 24. FUNERAL DIRECTOR McLaughlin Funeral Home, Inc. ADDRESS 2301 Lafayette Avenue | | 25. DATE RECD. BY LOCAL REG. JUL 20 1962 | 26. REGISTRAR'S SIGNATURE <i>Head Smith M.D.</i> |

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 *H. G. Ferris*

Licensed Embalmer No. 3384

P. O. Address *St. Louis*

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.