DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34445

Registration District No. 701 Primary Registration District No. Registrar's No. 8983

1. PLACE OF DEATH:

(a) County 1003 NOV 1 1939

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 30 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Bonne Terre NR
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 40 Years years.

3. (a) PRINT FULL NAME Aaron Goodman 955

3. (b) If veteran, name war No

3. (c) Social Security No. unk

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie Grodsky Goodman

6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Unk
(Month) (Day) (Year)

8. AGE: Years Ab. 60 | Months | Days | If less than one day hr. min.

9. Birthplace Lomze (City, town, or county) Poland (State or foreign country)

10. Usual occupation General Mdse. Retail

11. Industry or business

FATHER
12. Name Shoma Zalman Goodman
13. Birthplace (City, town, or county) Poland (State or foreign country)

MOTHER
14. Maiden name Gutka (unk)
15. Birthplace (City, town, or county) Poland (State or foreign country)

16. (a) Informant's own signature Louis Goodman
(b) Address Flat River Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H.B.Berger
(b) Address 4715 McPherson

19. (a) OCT 22 1939 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21
year 1939 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 5, 1939, to Oct 21, 1939;
that I last saw him alive on Oct 21, 1939
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death T.B. Meningitis	
T.B. Rt Kidney	
Due to Not Pulmonary	
Due to	
Other conditions — (Include pregnancy within 3 months of death) 24	
Major findings: Of operations —	
Of autopsy none done	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Benj. F. May (M. D. or other)
Address 539 N Grand Date signed 10.22.39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2597.....

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 this body is not embalmed, above space should be left blank.