

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16909

State File No. 4387

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution:
4174 Shaw Ave.
(d) Length of stay: In hospital or institution _____
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 4174 Shaw Ave.
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Esther Pearl Goade
8. (b) If veteran, name war No. 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 16
year 1940 hour 12.05 minute am M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: April 22 1914

21. I hereby certify that I attended the deceased from May 11
May 16, 1940, to May 16, 1940
that I last saw her alive on May 15, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
26 0 24 hr. min.

Immediate cause of death: Septicemia, due to sore throat non-diphtheritic
Ac. Cardiac failure
no definite heart disease
Duration 3 days
1 day

9. Birthplace Salem Missouri
10. Usual occupation Unemployed

Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Arvel Goade
13. Birthplace Salem Missouri
14. Maiden name Hattie Brocker
15. Birthplace Missouri

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

16. (a) Informant Mrs. Hattie Goade
(b) Address 4174 Shaw Ave.
17. (a) Removal (b) Date thereof 5-17-40
(c) Place: burial or cremation Salem, Mo.

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) MAY 16 1940 (b) _____
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) _____
(c) Means of injury _____
23. Signature Walter H. Hoff (D. or other) _____
Address 2602 S. Grand Date signed 5/16/40

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

MOTHER, FATHER

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

George W. Wilkinson

Licensed Embalmer No. 2575

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.