

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36871

FILED FEB 24 1947 318  
Registration District No.

Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: DeWitt General  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 days  
(Specify whether years, months or days) 3 years

3. (a) PRINT FULL NAME Edwin Goodin  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Belle 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased: (Month) 12 (Day) 28 (Year) 69

8. AGE: Years 79 Months 1 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: (City, town, or county) Lower (State or foreign country) Mo  
10. Usual occupation Miner

11. Industry or business \_\_\_\_\_  
12. Name Edwin Goodin  
13. Birthplace: (City, town, or county) Lower (State or foreign country) Mo  
14. Maiden name Belle  
15. Birthplace: (City, town, or county) ? (State or foreign country) Mo

16. (a) Informant Bessie Crites  
(b) Address 1818 So. 9th Street

17. (a) Removal (b) Date thereof 2-13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place of burial or cremation St. Louis, Mo

18. (a) Signature of funeral director A. W. McLaughlin  
(b) Address 230 Lafayette Ave. St. Louis, Mo  
19. (a) FEB 13 1947 (b) J. T. Bredon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 23 17  
(d) Street No. 1818 S. 9th St. (If rural, give location) 9  
(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15 year 1947 hour 10:00 minute 9 M.  
21. I hereby certify that I attended the deceased from Jan 26, 1947 to Feb 11, 1947 and that I last saw him alive on Feb 10 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Due to Chr. Valv. St. Disease  
Due to 92  
Other conditions (Include profession within 3 months of death) St. Barber MD  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature St. Barber MD (M. D. or other) \_\_\_\_\_  
Address 1504 S. Jefferson Date signed 2/12/47

**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..... *A W Cooper*.....

Licensed Embalmer No. *3830*.....

P. O. Address *2301 Lafayette Ave*

**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, fact should be so stated above.**