

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15114

FILED MAY 1 1947

1003

Registration District No. 318

Primary Registration District No.

Registrar's No. 4126

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution 3516 Olive St. Room - 61
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Leo Goodhart

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 45 1/2

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

8. AGE: Years 53 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation unk

11. Industry or business unk

12. Name unk

13. Birthplace unk (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Thos. J. Callahan

(b) Address 1300 Olive St

17. (a) Burial (b) Date thereof 4/21/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 21 1947 (Date received local registrar) J. F. Bredenk (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis
(c) City or town St. Louis
(d) Street No. 3516 Olive St. Room - 61
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month March day 23 year 1947 hour _____ minute 30

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Crown Thrombosis

Due to J. M. G.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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) _____
(e) Means of injury _____

23. Signature [Signature] (M.D. or other) _____
Address _____ Date signed 4/22/47

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..... **NO EMBALM**.....

Licensed Embalmer No.....

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, fact should be so stated above.