

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

FILED OCT 4 1948  
Registration District No. **37**

Primary Registration District No. **6076**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **Univ. City, Township**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **THE JEWISH SANATORIUM**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5 months, 6 days**  
In this community **5 months, 6 days**  
years, months or days

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

4. Sex **Female** 5. Color or race **Wh.** 6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **Meyer Goodman** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **unknown**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
about	85	--	--	hr. min.

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

10. Usual occupation **at home**

11. Industry or business \_\_\_\_\_

12. Name **Isaac Steinwurz**

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

14. Maiden name **unknown**

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

16. (a) Informant **Alexander M. Goodman**  
(b) Address **418 Olive St.**

17. (a) **Burial** (b) Date thereof **9-8-1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chesed Shel Emeth Cem.**

18. (a) Signature of funeral director **Herman Rindskopf, Inc.**  
(b) Address **5216 Delmar Blvd.**

19. (a) **9-8-48** (b) **Cecil A. Z. M...**  
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **96**  
(c) City or town **University City**  
(If outside city or town limits, write "RURAL") **5**  
(d) Street No. **743 Leland**  
(If rural, give location) **1**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **September** day **6**  
year **1948** hour **11** minute **45 P.M.**  
21. I hereby certify that I attended the deceased from **April 1**  
19 **48** to **Sept 6** 19 **48**  
that I last saw her alive on **Sept 6** 19 **48**  
and that death occurred on the date and hour stated above.  
Duration \_\_\_\_\_  
Immediate cause of death **Pneumonia due to fracture of femur**

Due to \_\_\_\_\_  
Due to **arteriosclerosis cerebral**  
Other conditions **ecetal.**  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **186w 18**  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

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 **Arno Goodman** (M. D. or other)  
**JEWISH SANATORIUM**  
Address **ROUTE 1 BOX 510** Date signed **9-6-48**

Robertson, Missouri

*John J. Fetter*  
*3880*

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 *John J. Fetter*  
Licensed Embalmer No. 3880

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 200  
Registrar's No. 2099

Registration District No. 317 Primary Registration District No. 6076

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 1/18/18 (Month) (Day) (Year)

8. AGE: all Years 30 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. min.)  
9. Birthplace Russia (City, town or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER {  
12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

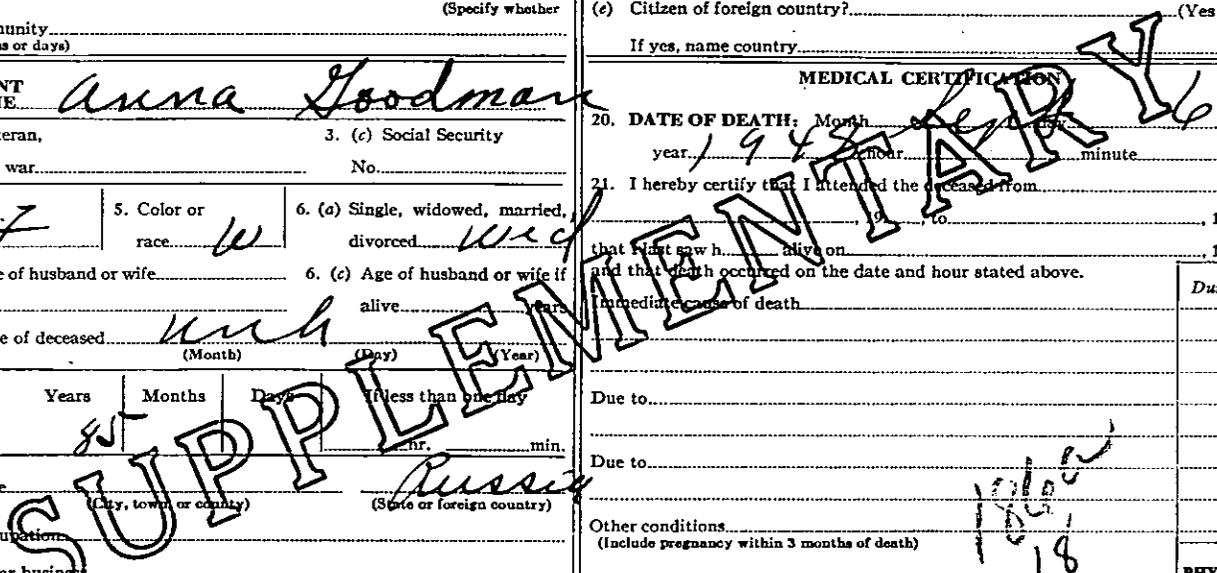
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 1 day 18 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 1918  
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:  
Fracture of left femur  
(a) Accident, suicide, or homicide (specify) Sept. 1, 1948  
(b) Date of occurrence  
(c) Where did injury occur? Jewish Sanatorium (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) Fell from chair (e) Means of injury  
23. Signature Miss [unclear] (M. D. or other)  
Address Jewish Sanatorium, Robertson, Missouri Date signed \_\_\_\_\_

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



S-31439