

FILED MAY 18 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17289  
3961  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Murphysboro	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 2101 Walnut Street	
3. NAME OF DECEASED (Type or Print) a. (First) Emanuel		c. (Last) Goodstein	
b. (Middle) <del>None</del>		4. DATE OF DEATH (Month) (Day) (Year) May 1, 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 7, 1886
9. AGE (In years last birthday) 62		10. KIND OF BUSINESS OR INDUSTRY Shoes	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Samuel Goodstein	
13b. MOTHER'S MAIDEN NAME Lena Rogoliner		14. NAME OF HUSBAND OR WIFE Lillian Goodstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Lillian Goodstein		ADDRESS Murphysboro Illinois	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<p style="text-align: center;"><b>MEDICAL CERTIFICATION</b></p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction</p> <p>ANTECEDENT CAUSES (b) Arterio Sclerotic Coronary Thrombosis</p> <p>(c) Arterio Sclerotic Heart Disease</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 2 months	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 942	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200	
22. I hereby certify that I attended the deceased from 4-10, 1949, to 5-1, 1949, that I last saw the deceased alive on 4-21, 1949, and that death occurred at 3:30 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Carl Klein M.D.		23b. ADDRESS 5-2-44	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 5/3/1949		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Hebrew	
24d. LOCATION (City, town, or county) (State) University City, Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson Ave.	
DATE REC'D BY LOCAL REG. MAY 3 1949		REGISTRAR'S SIGNATURE J. B. Laster	

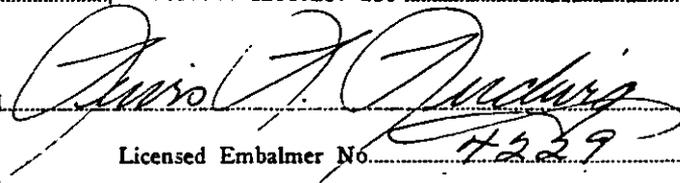
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_



Licensed Embalmer No. 7229

Signed \_\_\_\_\_  
Student Embalmer

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.