

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14304**

FILED MAY 1 - 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3892**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY ST. FRANCIS	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Flat River	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Annie	b. (Middle)	c. (Last) Goodman	4. DATE OF DEATH (Month) (Day) (Year) Apr. 24, 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 7, 1891	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 0 Days 17	IF UNDER 1 HR. Hours 17 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZENRY OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Hyman Harris	13b. MOTHER'S MAIDEN NAME Esther Ginsberg	14. NAME OF HUSBAND OR WIFE Jacob Goodman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Jacob Goodman-Flat River, Mo.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 81405
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF LUNG		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 163X
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22. I hereby certify that I attended the deceased from **SEPT 1951** to **APR 24, 1952**, that I last saw the deceased alive on **APR 24, 1952**, and that death occurred at **2:00** m., from the causes and on the date stated above.

23a. SIGNATURE Harry Eggen (Degree or title)	23b. ADDRESS 10634 N. Grand	23c. DATE SIGNED 4/24/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/25/52	24c. NAME OF CEMETERY OR CREMATORY B'Nai Amoona Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 25 1952 Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Harold ...	ADDRESS 5216 ...
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 10 1959

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 Peter B. Dubrouillet

Signed _____
Student Embalmer

Licensed Embalmer No. 3691

P. O. Address Richmond Heights

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.