

No. 30  
10. 48

REC NOV 27 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40502

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10839

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b>		b. (Middle) <b>J.</b>	c. (Last) <b>GOOD</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>NOVEMBER 13, 1953</b>		5. STREET ADDRESS (If rural, give location) <b>16 3400 S. Grand Blvd.</b>	

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 30, 1868</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS. Days <b>13</b>	Hours <b>13</b>	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo, 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		

13a. FATHER'S NAME <b>Franz Anton Good</b>	13b. MOTHER'S MAIDEN NAME <b>Anna M. Mohle</b>	14. NAME OF HUSBAND OR WIFE <b>Lena Good</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>John W. Good 3453 Miami St.</b>

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebro-Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerotic Cerebro-Vascular Disease</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetic Mellitus - ? Unknown</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>4221x</b>

22. I hereby certify that I attended the deceased from **10-29-53**, 19\_\_\_, to **11-13-53**, 19\_\_\_, that I last saw the deceased alive on **11-13-53**, 19\_\_\_, and that death occurred at **8:30A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph V. O'Donnell M.D.</b> (Degree or title)	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>11-14-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11/16/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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DATE REC'D BY LOCAL REG. <b>NOV 16 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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..

Student.....  
Signature of Student Embalmer

Signed..... *Robert F. Gebken*

Licensed Embalmer No. *414*

P. O. Address *2630 E*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.