

FILED APR 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13475**
Registrar's No. **2920**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN New Haven	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 0360	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital.			

3. NAME OF DECEASED (Type or Print)	a. (First) Alpheus	b. (Middle) C.	c. (Last) Goodrich	4. DATE OF DEATH (Month) (Day) (Year) Mar. 31, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Dec. 12, 1895.	9. AGE (In years) (Month) (Day) 58	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk	10b. KIND OF BUSINESS OR INDUSTRY Post Office	11. BIRTHPLACE (City and State or Foreign Country) New Haven, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles F. Goodrich	13b. MOTHER'S MAIDEN NAME Anna Arrott	14. NAME OF HUSBAND OR WIFE never married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.I	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Dr. H. A. Goodrich	ADDRESS #52 So. Rock Hill
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION Webster Groves.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rupture of arteriosclerotic anterior cerebral artery DUE TO (c) Arteriosclerotic Vascular Disease ?		
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 checked="" type="checkbox"/> NO <input 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) 331X
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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?
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22. I hereby certify that I attended the deceased from **May 27 7:45 AM** to **March 31, 1954**, that I last saw the deceased alive on **March 31, 1954**, and that death occurred at **7:45 AM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D.	23b. ADDRESS 634 N. Grand Blvd.	23c. DATE SIGNED 3-31-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-31-54	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) New Haven Mo
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DATE REC'D BY LOCAL REG. MAR 31 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

MAY 18 1957

MAY 22 1957

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 M. Murr*

Licensed Embalmer No. *379*

P. O. Address *St Louis*

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.