

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **17908**
Registrar's No. **4650**

FILED MAY 25 1956

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4650	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 21 2309 Division St. Apt. 101			
3. NAME OF DECEASED (Type or Print) Anthony Goolsby			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) 5 - 11 - 56	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never		8. DATE OF BIRTH October 30, 1954	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri	
12. CITIZEN OF WHAT COUNTRY? USA							
13a. FATHER'S NAME Steven Goolsby			13b. MOTHER'S MAIDEN NAME Bernice McCoy			14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernice Goolsby, 2309 Division St. Apt. 1			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Branch Pneumonia				INTERVAL BETWEEN ONSET AND DEATH _____			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				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 491x				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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:55 p. m., from the causes and on the date stated above.							
23a. SIGNATURE Joseph M. Deady (Degree or title) _____				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 5/14/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE May 16, 1956		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEMETERY		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. MAY 14 1956		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Baker & Son Funeral Home			
(Licensed Embalmer's Statement on Reverse Side)				3201 N. Newstead Ave.			

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

Missouri
 St. Louis
 Homer G. Phillips Hospital
 Anthony
 Male
 Colored
 never
 October 30, 1954
 I
 Goody
 2 - 11 - 58
 Apt. 101
 3209 Division St.
 St. Louis
 Infant
 Steven Goody
 Bertrice Goody
 Bertrice Goody
 none
 none
 Missouri
 St. Louis
 Missouri
 A2U
 Bertrice Goody, 3209 Division St. Apt. 101
 none
 Bertrice Goody
 none

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 *H. B. Claude Good*

Licensed Embalmer No. 34
 P. O. Address 45750

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F) to comply with the above constitutes grounds for revocation of license).
 If this body is not embalmed, fact should be so stated above.
 W. J. Baker & Son Funeral Home
 3201 N. Newstead Ave.