

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008357
STATE FILE NUMBER

FILED MAR 12 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 594

300
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Creve Coeur		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City 5 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Greenvalley Nurs. H. 7 Mos.		Length of stay in lb H. 7 Mos.	d. STREET ADDRESS (If outside, give location) 7831 Gannon Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MR. HERSCHEL Middle RALPH Last GOODMAN			4. DATE OF DEATH Month Feb. Day 23 Year 1958
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29 1891
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor (retired)	11. BIRTHPLACE (City and state or country) Woburn, Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Newton Floyd Goodman	
13b. MOTHER'S MAIDEN NAME Priscilla Mong		14. NAME OF HUSBAND OR WIFE Viola Twellman Goodman	
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. 489-05-9478	
17. INFORMANT Charles N. Goodman		Address 1082 Terrace Dr. 17	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis generalized 4/200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH instant several years. several years.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____		20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from July 20, 1957 to Feb 23, 1958 and last saw him alive on Feb 18, 1958 Death occurred at 11:20 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Dwyer, M.D. (Degree or title)		22b. ADDRESS Creve Coeur, Mo.	
22c. DATE SIGNED 2/24/58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Feb/ 26 1958		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
23d. LOCATION (City, town, or county) St. Louis County, Mo.		(State)	
24. FUNERAL DIRECTOR Alexander & Sons, Inc. 6175 Delmar		25. DATE RECD. BY LOCAL REG. 2-26-58	
26. REGISTRAR'S SIGNATURE Herbert R. Donke M.D.			

Dr. Robert G. Hughes
Olive St. Rd. & Old Ballas Rd.
HE. 2-2071

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 *Jos. E. McCulloch*

Licensed Embalmer No. *2460*
P. O. Address *6170 Rd*

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.