MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

2548

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 98

City St Louis (No. 3862 Folsom St. ..... Ward)

2. FULL NAME William P. Goffney

(a) Residence. No. 3862 Folsom St., 17 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose Klosper

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 13 - 1872

7. AGE: 55 YEARS | MONTHS: 1 | DAYS: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Building contractor
(b) General nature of industry, business, or establishment in which employed (or employer): 131 102
(c) Name of employer: 82A

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER: Jno Goffney
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER: Mary Goffney
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ireland

14. INFORMANT Rose Goffney
(Address) 3862 Folsom ave

15. FILED JAN - 3 1928, 19..... Max C. Starkloff REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 2nd 1928

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1927, to Jan 2nd, 1928, that I last saw h. ~~[illegible]~~ alive on Jan 2nd, 1928, and that death occurred, on the date stated above, at 1.30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
Due to hypertension
(Chronic)
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) ..... yrs. 8 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis & Blood pressure test
(Signed) H C Klosper, M. D
Jan 3, 1928 (Address) 3860 S. Broadway

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary Cem | DATE OF BURIAL: 1/5 1928

20. UNDERTAKER: Fros J Finan | ADDRESS: 15798 Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

H C. Kloeffer
3860 S Bway