

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

Do not use this space.

14090

1. PLACE OF DEATH

County Carroll Registration District No. 135
Township _____ Primary Registration District No. 3010
City Carrollton (No. _____) St. _____ Ward _____

File No. _____
Registered No. 43

2. FULL NAME Louise Goedeke

(a) Residence. No. _____ St. _____ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carl Goedeke

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-2-1889
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 4 12

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Carroll Co.
(STATE OR COUNTRY) Mo

10. NAME OF FATHER August Steik

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Agnes Thoeni

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Germany

14. INFORMANT Carl Goedeke
(Address) Carrollton Mo

15. FILED 4-15-1929 Mrs. E. F. Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-14-1929

17. I HEREBY CERTIFY, That I attended deceased from 4-1-1929, to 4-14-29, 1929, that I last saw him alive on 4-1-29, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pericarditis Pleurisy
1929

CONTRIBUTORY (SECONDARY) 1310
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) H. M. Renow M. D.

, 19 (Address) Carrollton Mo

*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 Oak Hill Cem DATE OF BURIAL 4-17 1929

20. UNDERTAKER Standley ADDRESS Carrollton Mo

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.

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1929

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