WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

21144

File No. 5695

Registered No.

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH

County

Township

City St. Louis (No. City Hospital #1 St. Ward)

#3228

2. FULL NAME Mathias Godefroid

(a) Residence, No. 3115 So. Broadway St. 24 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 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~~ Margaret Godefroid

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 20 1860

7. AGE: Years 72 Months 5 Days 25 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Civil Labor

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 93

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 35

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

FATHER

13. NAME Peter Godefroid

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Elizabeth Schneider

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Hospital Information (ADDRESS) City Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olive Cem. DATE 6/17 1932

19. UNDERTAKER C. Hoffmeister Undertaker (ADDRESS) 7840 Le Beau

20. FILED JUN 16 1932 19 Max C. Starcke Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 14, 1932

22. I HEREBY CERTIFY, That I attended deceased from May 25, 1932, to June 14, 1932

I last saw h. ~~m.~~ alive on June 14, 1932 Death is said to have occurred on the date stated above, at 8:40 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Cystitis	Unknown
Chronic Myocarditis	Unknown

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Carl H. Hoff, M. D.

(Address) City Hospital #1