

FEB 16 1938

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

4078
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 1170
(b) Township Jefferson Primary Registration District No. 6248-H Registered No. 258
(c) City Richmond Mts. (d) Street No. ST. MARY'S HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. 30 mos. 8 ds. 2 (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME WILTON GOCKEL W. U. D.

(a) Residence, No. 5503 PLOVER AVE St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **SINGLE**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 8 1937

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

22. I HEREBY CERTIFY, That I attended deceased from Nov. 11 1937, to Dec 8 1937

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APR. 6, 1907

I last saw h. us alive on Dec 8 1937 Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 30 8 2

to have occurred on the date stated above, at 7:15 P.M.
The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. STENOGRAPHER 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

Multiple Abscess Brain Postoperative + P. Hospital
8212

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS, MO.

Other contributory causes of importance:
Embolic, Splenic Bone
Sepsis, Splenic Abscess
Septic Hemorrhage

FATHER 13. NAME WILLIAM GOCKEL

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MADISON IOWA

Name of operation Radical Splenectomy Date of 12/13
What test confirmed diagnosis? Was there an autopsy? Yes

MOTHER 15. MAIDEN NAME ELIZABETH ISRAEL

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS, MO.

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.

17. INFORMANT WILLIAM GOCKEL
(ADDRESS) 5503 PLOVER AVE

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY CEMETERY DATE DEC. 11, 1937

Manner of injury Nature of injury

19. FUNERAL DIRECTOR Goodhart & Goodhart
(ADDRESS) 2228 St. Louis Ave

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify (Signed) Wm. H. D. M. D.

20. FILED Dec 10, 19 Sam W. Bassett
Local Registrar.

(Address) County Clerk Bldg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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STATEMENT BY LICENSED EMBALMER

I, Charles Goodhart

Licensed Embalmer No. 2777

hereby certify that the body recorded on the reverse side of this certificate was embalmed by: Charles Goodhart

L. E.

No. _____ or by _____

Registered Apprentice No. _____

working under my personal supervision.

Signed

Charles Goodhart

Licensed Embalmer No. 2777

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)