

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
SEP 14 1939

State File No. 27576
Registrar's No. 7076

Registration District No. 791
1003

Primary Registration District No. _____

1. PLACE OF DEATH: 1003
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 629 Bates St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 14
(If outside city or town limits, write "RURAL")
(d) Street No. 5057a Chippewa St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 35 years.

3. (a) PRINT FULL NAME Katie Goetz 320
(b) If veteran, name war None
(c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank Goetz
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased October 5th 1879
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 12th
year 1939 hour 7 minute 52 P. M.
21. I hereby certify that I attended the deceased from Apr 20-1939
to Aug 12, 1939
that I last saw her alive on July 22, 1939
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
59 10 7 hr. _____ min.

Immediate cause of death Myocarditis Chronica 1 Known
Due to My pertussis Ch 1 Known
Septic Ch 1 Known
Staphylococcus Ch 1 Known

9. Birthplace Hungary
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: Of operations none
Of autopsy none

MOTHER FATHER
11. Industry or business _____
12. Name Unknown Schenk
13. Birthplace Hungary
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Hungary
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Frank Goetz
(b) Address 5057a Chippewa St.
17. (a) Burial (b) Date thereof 8-16-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Peter & Paul
Kriegshausner Mortuaries
18. (a) Signature of funeral director 4228 So. Kingshighway
(b) Address _____
19. (a) AUG 15 1939 (b) _____
(Date received local registrar) (Signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Robert G. Brown (M. D. or other) MD
Address 1115 Paul Brown Bldg Date signed Aug 15-39

Dr. Robert Warner
1115 Paul Brown Bldg. 10-3

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Edwin D. Mc Dermott

Licensed Embalmer No. 3024

P. O. Address.....

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 this body is not embalmed, above space should be left blank.