

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**3355 Oak Hill**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **Life.** \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Amanda E. Goetz**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widow**  
6. (b) Name of husband or wife **Henry** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Sept. 20th 1864.**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**77** **8** **7** \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **St. Louis, Mo.** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business \_\_\_\_\_

12. Name **Adam Erder**  
13. Birthplace **Germany** \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name **Not known**  
15. Birthplace **Not known** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter J. Goetz**  
(b) Address **3355 Oak Hill**

17. (a) **Burial** (b) Date thereof **5/30/42**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **New Pickers Cem.**

18. (a) Signature of funeral director **John R. Ziegenhain & Sons**  
(b) Address **7027 Gravois Ave.,**

19. (a) **MAY 30 1942**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis, Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3355 Oak Hill Ave.,** \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? **No.** \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27th**  
year **1942** hour **5** minute **P** M.  
21. I hereby certify that I attended the deceased from **May 27**  
19 **42** to **May 27** 19 **42**  
that I last saw **her** alive on **May 27** 19 **42**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial failure**  
**from Chronic Myocarditis**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **Hypostatic Pneumonia**  
(Include pregnancy within 3 months of death) **2 days**

Duration

**2 Months**

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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 **Arnold S. Klein** (M. D. or other) \_\_\_\_\_  
Address **2637 South Kingshighway** Date signed **5-28-42**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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..... *C. P. K. duvell* .....  
Licensed Embalmer No. *3877* .....  
P. O. Address *7027 Grains* .....

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16175-

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4732

1. PLACE OF DEATH:

(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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Life  
years, months or days)

3. (a) PRINT FULL NAME Amanda E. Goetz

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept-20-1864  
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. JUL 17 1942 (Date received local registrar) (b) J. F. Brudeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3355 Oak Hill Ave  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1942  
5-16175