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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 13 1944
318

Primary Registration District No. 1003

Registrar's No. 2133

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: City Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether
In this community 30 years
years, months or days)

3. (a) PRINT FULL NAME FLORA GOFF

3. (b) If veteran, name war - 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

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

7. Birth date of deceased Sep't 25, 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 5 7 _____ hr. _____ min.

9. Birthplace Piedmont Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER

12. Name not known

13. Birthplace not known (City, town, or county) (State or foreign country)

14. Maiden name not known

15. Birthplace not known (City, town, county) (State or foreign country)

16. (a) Informant Thelma A. Singler
(b) Address 5400 Arsenal

17. (a) Burial (b) Date thereof Mar. 3, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Beiderwieden F.H., Inc.
(b) Address 1936 St. Louis,

19. (a) MAR 3 1944 (b) J. J. Budick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1607 N. 25th St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1944 hour 12:10 minute _____ P. M.

21. I hereby certify that I attended the deceased from Febr 21 1944 to March 2 1944;
that I last saw her alive on March 2 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Infarction due to
Gangrene of left leg
Due to Diabetes

Duration
1 day
1944x

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy yes

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 C. T. Mc Cormick (M. D. or other) MD
Address 5400 Arsenal Date signed 3/2/44

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

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.....

No Embalmer

....., Registered Apprentice No.....

working under my personal supervision.

Signed *[Signature]*.....

Licensed Embalmer No. *3737*.....

P. O. Address *1936 1/2 St. Louis*.....

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.