

FILED APR 1 1944
818

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 2866

1. PLACE OF DEATH:

(a) County Mo. St. Louis Mo.
(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: St. Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 91
(If outside city or town limits, write "RURAL")
(d) Street No. 5504 Idaho Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SUSANNA-GOLDIAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. female 5. Color or race white 6. (a) Single, widowed, married, divorced divorced, widowed
6. (b) Name of husband or wife Walter Goldian 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased Sep 24 1876
(Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name unknown
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name unknown
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant John Goldian
(b) Address 5504 Idaho

17. (a) burial (b) Date thereof Mar 29 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New S. S. Peter & Paul cemetery

18. (a) Signature of funeral director Helmut Imberowicz

(b) Address 5401 S. Grand

19. (a) MAR 29 1944 (b) J. Z. Brudick
(Date received local record) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1944 hour 3 o'clock minute 0 A. M.

21. I hereby certify that I attended the deceased from Mar 24 1944 to March 26 1944

that I last saw her alive on _____ 1944

and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Coma Duration 2 yrs

Due to 61

Due to _____

Other conditions Myocarditis, Arteriosclerosis 2 yrs
(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 W. D. Schaefer (M. D. or other) _____

Address 3318 So Grand Date signed 3-27-44

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.....

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

working under my personal supervision.

Signed

John J. Gionoski

Licensed Embalmer No. *3398*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2866

Registration District No. 318 Primary Registration District No. 1003

APR 5 1946

1. PLACE OF DEATH:

(a) County _____
(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 _____ years, months or days

3. (a) PRINT FULL NAME Susanna Goldan
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. 24 1891
(Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ If less than one day _____ min.
9. Birthplace Coblenz
(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) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____

19. (a) APR 7 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 6 Year 1946 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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 _____

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

SUPPLEMENTAL

MOTHER FATHER

FILED

2898