S. No. 2
4—8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 25679

FILED AUG 24 1945 18

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 7106

**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: 3848 Shenandoah Ave. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 003 17

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3848 Shenandoah Ave. 9
(If rural, give location)

(e) Citizen of foreign country? 9 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME George U. Goetz

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Lucille Lily Goetz

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased September (Month) 16 (Day) 1899 (Year)

8. AGE: Years 45 | Months 10 | Days 25 | If less than one day _____ hr. _____ min.

9. Birthplace Chicago (City, town, or county) Illinois 1 6 (State or foreign country)

10. Usual occupation Investigator

11. Industry or business _____

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Mrs. Lucille Goetz
(b) Address 3848 Shenandoah Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-13-45 (Month) (Day) (Year)
(c) Place: burial or cremation Quincy, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 1 1945 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 11 year 1945 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism
Thrombosis Phlebitis, left
Femoral Vein

Due to (or as a consequence of) Place, Cancer
Uterus of Uterine Cavity

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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) Open Verdict

(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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D.) Date signed 8/13/45

Address _____

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 25 1945

7406

7406

SEP 20 1945

## 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 Albert G. Koppe

Licensed Embalmer No. 2971

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.**