

No. 2
1-5-43
5-17-39
I X36571

FILED SEP 1 1945
318

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7277**

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:
Deaconess Hospital
(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jerrie Golden

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased November 8 1942
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>2</u>	<u>9</u>	<u>11</u>	hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Fred Golden

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

14. Maiden name Verna Wilson

15. Birthplace Unknown Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Golden

(b) Address 1923 N. 9th St.

17. (a) Burial (b) Date thereof 8-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 20 1945 (Date received local registrar)

J. F. Brewer (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1923 N. 9th St.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19
year 1945 hour 6:00 minute P. M.

21. I hereby certify that I attended the deceased from Aug. 15 1945 to Aug. 19 1945
that I last saw him alive on Aug. 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Stricture of esophagus Duration 6 wks.

Due to Swallowing of legs!

Due to _____

Other conditions Acute pneumonia 2 day
(Include pregnancy within 3 months of death)

Plurial effusion

Major findings:
Of operations _____

Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

1 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 T. S. Zehorsky (M. D. or other) M.D.

Address 536 N. Taylor Date signed 8-22-45

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.....

W. Wilkins

Licensed Embalmer No. 3575

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.

Registration District No. 318

Primary Registration District No. 1003

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 _____
years, months or days)

3. (a) PRINT FULL NAME

Jemie Golden

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Nov (Month) 10 (Day) 1945 (Year)

8. AGE: Years 2 Months 9 Days no (Unless 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 _____

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. (a) _____ (b) _____
(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 _____
year 1945 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ to _____, 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

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:

(d) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence June 15, 1945

(c) Where did injury occur? Poplar Bluff (City or town) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? _____ (Specify type of place) (e) Means of injury Swallowed by

23. Signature T. S. Zahorsky (M. D. or other) L. M. D.

Address 536 N. Taylor Date signed _____

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

1948

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1945
S-25680
