

7. S. No. 2
DM-9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

JAN 21 1946 STANDARD CERTIFICATE OF DEATH

State File No. 4000

Registration District No. 317

Primary Registration District No. 3669

Registrar's No. 149

1. PLACE OF DEATH: *St. Louis*

(a) County *Richmond Heights*

(b) City or town *Richmond Heights*

(c) Name of hospital or institution: *St. Mary's Hospital*

(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution *5 hours*

(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO.* (b) County *St. Louis*

(c) City or town *St. Louis County*

(If outside city or town limits, write "RURAL")

(d) Street No. *1/2 West of Snoede Rd. on Conway Rd.*

(If rural, give location)

(e) Citizen of foreign country? *1* (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME *COLONEL JOHN C. GOT WALS*

3. (b) If veteran, name war *World War I* 3. (c) Social Security No. *None*

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

6. (b) Name of husband or wife *Muriel Roberts* 6. (c) Age of husband or wife if alive *45* years

7. Birth date of deceased *Nov. 11th 1881*

8. AGE:	Years	Months	Days	If less than one day
	<i>61</i>	<i>6</i>	<i>2</i>	<i>11</i> hr. <i>57</i> min.

9. Birthplace *Yerkes Pennsylvania*

10. Usual occupation *Retired U.S. Army Colonel*

11. Industry or business _____

12. Name *Abraham Gotwals*

13. Birthplace *Yerkes Pennsylvania*

14. Maiden name *Mary C.*

15. Birthplace *Pennsylvania*

16. (a) Informant *Bernard A. Purcell*

(b) Address *#11 Conway Rd.*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *1-17-46*

(c) Place: burial or cremation *Calvary Cemetery*

18. (a) Signature of funeral director *Robert J. Ambruster*

(b) Address *Clayton Rd. & Concordia Lane*

19. (a) *1-17-46* (Date received local registrar) (b) *S. B. M. Baranoff* (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *1* day *15* year *1946* hour *3* minute *25* P.M.

21. I hereby certify that I attended the deceased from *1/14* 19 *46* to *1/15* 19 *46* that I last saw him alive on *1/14* 19 *46* and that death occurred on the date and hour stated above.

Immediate cause of death *Virus pneumonia* Duration *24 hr?*

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy *Upper lobes of both lungs hemorrhagic. Several toxic signs.*

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 *Richard D. H. Fleck* (M. D. or other) *M.D.*

Address *St. Mary's Hosp* Date signed *1/15/46*

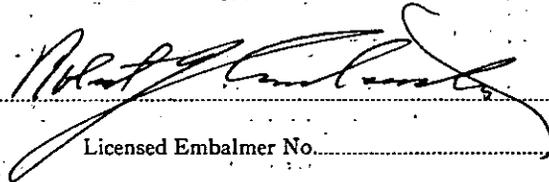
2005
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 25 1946

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



.....
Licensed Embalmer No.....

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.