DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 17 1946

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 42425

Registrar's No. 10491

1. PLACE OF DEATH:

(a) County MISSOURI

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ALEXIAN BROS. HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community 27 YRS.
years, months or days)

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. 2926 VICTOR
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ROY B. GOTT

3. (b) If veteran, name war

3. (c) Social Security No. 493-07-3622

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of ~~husband~~ or wife VERNA

6. (c) Age of ~~husband~~ or wife if alive 42 years

7. Birth date of deceased AUGUST (Month) 20 (Day) 1901 (Year)

8. AGE:

Years	Months	Days	If less than one day
45	3	16	hr. min.

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

10. Usual occupation MACHINIST

11. Industry or business

FATHER
12. Name LUCIEN GOTT
13. Birthplace ILLINOIS (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name LINNIE KELCH
15. Birthplace ILLINOIS (City, town, or county) (State or foreign country)

16. (a) Informant VERNA GOTT
(b) Address 2926 VICTOR

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 10 1946 (Month) (Day) (Year)
(c) Place: burial or cremation ST. JACOB'S ILLINOIS

18. (a) Signature of funeral director Thos. Kutis & Son
(b) Address 2906 GRAVOIS

19. (a) DEC 8 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 6
year 1946 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from 5-27-46, 19__, to 12-6-46, 19__;
that I last saw him alive on 12-6-46, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute myelogenous leukemia — Duration: 1 week
Due to: Anemia — 6 mon
Due to:
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John D. Stein (M. D. or other)
Address 2840 Gilfoyle Date signed 12-7-46

(Licensed Embalmer's Statement on Reverse Side)

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. Leo J. Budde

Licensed Embalmer No. 3989

P. O. Address. St. Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.