

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED JUN 13 1947

Registration District No.

Primary Registration District No. 1003

Registrar's No. 5507

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... City St. Louis MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmary Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12/7/45/6/2/47
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Kathryn Goessling

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

4. Sex..... Female 5. Color or race..... White
6. (a) Single, widowed, married, divorced..... U
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... 10 23 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 7 9 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
12. Name..... Ralph Goessling
13. Birthplace..... St Louis Mo
(City, town, or county) (State or foreign country)
14. Maiden name..... Faye Nace
15. Birthplace..... St Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant..... City Infirmary Records
(b) Address..... 5800 Arsenal St.

17. (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... St. Peter's Cem

18. (a) Signature of funeral director..... Stroot - Carroll
(b) Address..... 4600 Natural Bridge Ave

19. (a) JUN 3 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... 000
(c) City or town..... City
(If outside city or town limits, write "RURAL")
(d) Street No..... 5800 Arsenal St.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... 6 day..... 2
year..... 1947 hour..... 10 minute..... 30 p. M.

21. I hereby certify that I attended the deceased from 12/7
7 19 45 to 6 12 19 47
that I last saw her alive on 6 12 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Congenital hydrocephalus
Congenital renal insufficiency
Due to..... Central nervous system
Due to..... Edema of the lung
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
157
PHYSICIAN
Underline the cause of 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?..... Means of injury.....
23. Signature..... [Signature] (M. D. or other)
Address..... 5600 Arsenal Date signed..... 6-3-47

WRITE PLAINLY—USING 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.....

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.