No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 20 1947

Registration District No. 37

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 36631

Registrar's No. 2199

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Veterans Admn. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 months 23 days (Specify whether years, months or days)
In this community 20 years

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. 1809 Delmar Blvd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME COEHE, Benjamin
3. (b) If veteran, name war WW-1
3. (c) Social Security No. Unknown
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 January (Month) 20 (Day) 1889 (Year)

8. AGE: Years	Months	Days	If less than one day
58	8	26	hr. min.

9. Birthplace Stautnon, Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation Cigar man
11. Industry or business Tobacco
FATHER
12. Name William Goehe
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
16. (a) Informant Registrar
(b) Address Jefferson Barracks, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation Staunton, Illinois
18. (a) Signature of funeral director A.H.Hoppe Fun.Home
(b) Address 4700 Washington, St. Louis, Mo.
19. (a) 10-17-47 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16th year 1947 hour 7 minute 40 P.M.
21. I hereby certify that I attended the deceased from December 23, 1946 to October 16, 1947 that I last saw him alive on October 16, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinomatosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? —
While at work? — (Specify type of place) (e) Means of injury
23. Signature L.E. Stilwell (M. D. XXXX)
L.E. STILWELL
Address Jefferson Barracks, Mo. Date signed 10/17/47

Jefferson City Printing Co.

(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 Ernest W. Spillar

Licensed Embalmer No. 4080

P. O. Address.....

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

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

VETERANS ADMINISTRATION
HOSPITAL
Jefferson Barracks, Mo.

October 30, 1947

YOUR FILE REFERENCE:

IN REPLY REFER TO: 8D
GOEHE, Benjamin
XC-1488 756

Special Agent
U.S. Public Health Service
Division of Health
Jefferson City, Missouri

Dear Sir:

Referring to your request of recent date relative to more complete information on Death Certificate.

No autopsy was performed in this case and primary site was not determined. The only diagnosis suggested was given on a pathological report, Tumor, abdominal, possibly hypernephroma.

Very truly yours,

L. E. Stilwell

L. E. STILWELL, M.D.
Clinical Director

n inquiry by or concerning an ex-service man or woman should, if possible, give veteran's name and file number, whether C, XC, K, N, or V. If such file number is unknown, service or serial number should be given.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. N 02

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 299

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Jefferson Barracks
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Benjamin Hoche
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Jan 20 1888 (Month) (Day) (Year)
8. AGE: Years 58 Months 8 Days 26 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country) Ill
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 6 year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY