

S. No. 300  
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ev. 5-17-39  
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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED MAY 15 1948  
Registration District No. 377

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14933  
Registrar's No. 1108

Primary Registration District No. 3064

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Ferguson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
426 Chambers Rd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether  
In this community 3 weeks  
years, months or days)

3. (a) PRINT FULL NAME Wilhelmina K. Gohn  
3. (b) If veteran, name war ---  
3. (c) Social Security No. 124-09-6211

4. Sex F / 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Peter Gohn  
6. (c) Age of husband or wife if alive Dec'd years  
7. Birth date of deceased Sept. 13 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 7 19 hr. min.

9. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Sewing operator

11. Industry or business Garment

12. Name Joseph Kuehn

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Thomas Gohn

(b) Address Ferguson, Missouri.

17. (a) Burial (b) Date thereof 5/6/48.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Long Island City, N. Y.

18. (a) Signature of funeral director White Funeral Home

(b) Address 118 N. Florissant

19. (a) 5-3-48 (b) Geary Sharp MD  
(Date received local registrar) (Registrar's signature) me

2. USUAL RESIDENCE OF DECEASED:  
(a) State New York (b) County Queens 911  
(c) City or town Long Island City. 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 42-39 Twnty Fourth St.  
(If rural, give location)  
(e) Citizen of foreign country? --- (Yes or No)  
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2  
year 1948 hour 9: minute 45 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_ 200

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? Y.

(Specify type of place)  
While at work? \_\_\_\_\_ (b) Means of injury \_\_\_\_\_  
d. Geary Sharp MD (M. D. number) 5-5-48  
23. Signature of \_\_\_\_\_  
Address Commissioner of Health Date signed \_\_\_\_\_

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**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 L. M. White

Licensed Embalmer No. 3973

P. O. Address Berqueman, Mo.

**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.**