

FILED MAY 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17286

BIRTH NO. 8.3065-48 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4078

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo			b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 11 weeks	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 6323 JUNIATA						
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns			3. NAME OF DECEASED a. (First) REGINA			b. (Middle) CLARE		c. (Last) GOGGINS	4. DATE OF DEATH (Month) (Day) (Year) MAY 5 1949		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH DEC 4 1948		9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis Mo.			12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME JAMES GOGGINS			13b. MOTHER'S MAIDEN NAME CATHERINE O'BRIEN			14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME James Goggins			ADDRESS 6323 Junjata			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION Acute Lymphatic Leukemia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 weeks		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION Acute Bronchitis						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? 2040						
22. I hereby certify that I attended the deceased from Dec 19, 1948, to May 5, 1949, that I last saw the deceased alive on May 5, 1949, and that death occurred at 8 a.m., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) George A. Colloidi M.D. U					23b. ADDRESS 4500 Olive St.			23c. DATE SIGNED May 5, 1949			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4-7-49	24c. NAME OF CEMETERY OR CREMATORY CALVARY			24d. LOCATION (City, town, or county) (State) St. Louis MO					
DATE REC'D BY LOCAL REG. MAY 6 1949		REGISTRAR'S SIGNATURE J. B. Laster			5. FUNERAL DIRECTOR'S SIGNATURE Cuffman-Kelly			ADDRESS 4386 Lindell			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

James A. Lammers

Signed _____

Student Embalmer

Licensed Embalmer No. _____

4142

P. O. Address _____

St Louis

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.