

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

24826

State File No.

318

1003

6646

BIRTH NO. # 6391 REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis City Hospit	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 85-419 Cole St.,	

3. NAME OF DECEASED (Type or Print) a. (First) Adolph b. (Middle) c. (Last) Gocker			4. DATE OF DEATH (Month) (Day) (Year) 6 20 1949		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unknown	
8. DATE OF BIRTH 2/23			9. AGE (In years last birthday) 67 If under 1 year: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY?		

13a. FATHER'S NAME Daniel Gocker		13b. MOTHER'S MAIDEN NAME Mary Adam		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS M. Renard St. Louis City Hospital	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Bladder				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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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) 521			
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 181X			
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22. I hereby certify that I attended the deceased from 6-14-49, to 6-20-49, 1949, that I last saw the deceased alive on 6-20-49, 1949, and that death occurred at 8:00 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D. Carter		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 6-21-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE JUL 31 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
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DATE REC'D BY LOCAL REG. JUL 31 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service			
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

X *winning*

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.

Student
Student Embalmer

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.