

FILED DEC 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36306**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **289**

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

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Columbia</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Columbia</b>	
c. LENGTH OF STAY (in this place) <b>1 Day</b>		d. STREET ADDRESS (If rural, give location) <b>612 College Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Boone County Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>JOSEPH</b> b. (Middle) <b>GERARD</b> c. (Last) <b>GOEKE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 28, 1949</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 20, 1883</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Manager of Missouri Farmer's Assn.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Missouri</b>		11. BIRTHPLACE (State or foreign country) <b>0</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Joseph Goeke</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Stroot</b>		14. NAME OF HUSBAND OR WIFE <b>Selma Rienhardt Goeke</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Joseph G. Goeke, Columbia, Mo.</b>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Ruptured aneurysm</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis &amp; hypertension</b>				<b>12 years</b>
		DUE TO (c) _____				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>4500</b>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **5-9, 1949**, to **11-28, 1949**, that I last saw the deceased alive on **11-28, 1949**, and that death occurred at **3:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>James H. Allen M.D.</b>	23b. ADDRESS <b>Columbia, Mo.</b>	23c. DATE SIGNED <b>11-29-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec. 1, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Nov. 29 1949</b>	REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>31 Parker Funeral Service Columbia, Mo.</b>
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RECEIVED  
MAR 10 1949

RECEIVED DEC 5 1949  
District Health Officer No. 9,  
District File Number

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 M. S. Whitides

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3893

P. O. Address Columbia 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.