

FILED APR 4 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12616

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 797c

4002
C

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON MO.</u>	c. LENGTH OF STAY (In this place) <u>2 DAYS</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>4224 Lee Ave. 2109</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>-----</u> c. (Last) <u>Goetz</u>			4. DATE OF DEATH (Month) <u>3</u> (Day) <u>12</u> (Year) <u>53</u>		
--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 14 1884</u>		9. AGE (In years last birthday) <u>68</u>	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) <u>Plaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	---	--	--	--

13a. FATHER'S NAME <u>Henry Goetz</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret</u>		14. NAME OF HUSBAND OR WIFE <u>Single</u>	
---------------------------------------	--	---	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-01-8240</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Minnie Weber</u> ADDRESS <u>4021 Russell St. Louis</u>		
--	--	--	---	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Convulsion</u>		DUE TO (b) <u>Multiple Fractures</u>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>Compound Fr. RT Ilium</u>			
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 <u>400 E802X</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
------------------------------	---	--	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Predominant</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>R.R. Tracks</u>	21c. (CITY, TOWN, OR TOWNSHIP) <u>JENNINGS</u> (COUNTY) <u>ST. LOUIS</u> (STATE) <u>MO</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Mar. 10, 1953 3:00 PM</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Struck by Train</u>

22. I hereby certify that I attended the deceased from 3-10-, 1953, to 3-12-, 1953, that I last saw the deceased alive on 3-12-, 1953, and that death occurred at 1:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. Melvin P. Kasten M.D.</u>		23b. ADDRESS <u>601 S. Brentwood Clayton Mo.</u>		23c. DATE SIGNED <u>3-13-53</u>	
---	--	--	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Mar. 16, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
---	--------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>3-13-53</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Dombke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wacker Undertakers</u>	ADDRESS <u>3634 Gravois</u>
---	---	--	-----------------------------

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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 9675
P. O. Address St Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.