

FILED FEB 2 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2823**  
Registrar's No. **0710**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Illinois</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY OR TOWN <b>Mt. Vernon</b>	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>6 days</b>		e. STREET ADDRESS (If rural, give location) <b>503 South 15th st.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b> b. (Middle) <b>H.</b> c. (Last) <b>GOTT</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>1-15-54</b>		
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>10-7-1896</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>area manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ill. Power Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Centralia, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>J. A. Gott</b>		13b. MOTHER'S MAIDEN NAME <b>Martha McClellan</b>		14. NAME OF HUSBAND OR WIFE <b>Myrtle Gott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes WW#1</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Myrtle Gott, Mt. Vernon, Ill.</b>	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cor Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Peritonitis</b>			<b>4 days</b>
	DUE TO (c) <b>Perforated Duodenal Ulcer</b>			<b>6 days</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION <b>1-11-54</b>	19b. MAJOR FINDINGS OF OPERATION <b>Stenosing Perforated Duodenal Ulcer</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
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? <b>5411</b>	

22. I hereby certify that I attended the deceased from **1-9-54**, 19**54**, to **1-15-54**, 19**54**, that I last saw the deceased alive on **1-15-54**, 19**54**, and that death occurred at **7:45 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W. Schupel M.D.</b>	(Degree or title)	23b. ADDRESS <b>634 N. Grand, St. Louis Mo.</b>	23c. DATE SIGNED <b>1-22-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>1-18-54</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, Ill.</b>
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DATE REC'D BY LOCAL REG. <b>JAN 23 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Myers F.H.</b>	ADDRESS <b>Mt. Vernon, Ill.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Ronald O. York*

Licensed Embalmer No.....

P. O. Address.....  
*St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.