

FILED DEC 13 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38765**  
Registrar's No. **9865**

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>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. John</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Baptist Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place)		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 29, 1954</b>	
e. STREET ADDRESS <b>2819-Endicott Avenue</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ella</b> b. (Middle) <b>Nora</b> c. (Last) <b>Goetz</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 29, 1954</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>Sept. 16, 1875</b>		9. AGE (in years last birthday) <b>79</b>		10. IF UNDER 1 YEAR: Months Days 11. IF UNDER 10 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13a. FATHER'S NAME <b>Christian Goetz</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>John Dcd.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Lester Goetz</b>		17. ADDRESS <b>2512-Brown Road</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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CORONARY OCCLUSION</b> <b>Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic C.V. Disease</b> <b>Hypertensive C.V. disease</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>1 mos.</b> <b>10 plus</b> <b>"</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT (Specify) <b>SUICIDE</b> <b>HOMICIDE</b>		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>443X</b>	
22. I hereby certify that I attended the deceased from <b>10-29</b> , 19 <b>54</b> , to <b>10-29-54</b> , 19____, that I last saw the deceased alive on <b>10-29-54</b> , 19____, and that death occurred at <b>3.30 PM</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>John A. Kennedy M.D. M.D.</b>		23b. ADDRESS <b>8733 Riverview St. Louis 21</b>		23c. DATE SIGNED <b>10-30-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>11-1-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Park</b>	
24d. LOCATION (City, town, or county) (State) <b>Wellston, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Saunam Bros Inc.</b>		25. ADDRESS <b>2504 Woodson Rd-Overland-14-Mo.</b>	

DATE REC'D BY LOCAL REG. <b>NOV 1 1954</b>		REGISTRAR'S SIGNATURE <b>J. C. Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Saunam Bros Inc.</b>		25. ADDRESS <b>2504 Woodson Rd-Overland-14-Mo.</b>	
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WRITE PLAINLY—USING UNFADEING 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 *Oscar F. Mueller*

Licensed Embalmer No. *30*

P. O. Address *Quincy*

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.