

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43485**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11534**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY 2059	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	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) 82 yrs		e. STREET ADDRESS (If rural, give location) 5475 Cabanne Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			
5 Winston Churchill Apts			

3. NAME OF DECEASED (Type or Print) a. (First) Abby b. (Middle) Goddard c. (Last) Chamberlain			4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1954		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 29, 1871	9. AGE (In years last birthday) 83 yrs	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Brookline, Mass.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jos. Warren Goddard		13b. MOTHER'S MAIDEN NAME Maria Pierson		14. NAME OF HUSBAND OR WIFE Frederick B. Chamberlain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Frederick B. Chamberlain Winston Churchill	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Pancreas DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. Fracture left Hip, left Shoulder			INTERVAL BETWEEN ONSET AND DEATH 9 wks 1 yr 3 weeks
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	-------------------------------------------------------------------------------------------

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis MO	
21d. TIME OF INJURY 11-27-54 ? m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? fell at home 157XF	

22. I hereby certify that I attended the deceased from **Jan**, 1954, to **Dec 18**, 1954, that I last saw the deceased alive on **Dec 17**, 1954, and that death occurred at **5 a.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul Kingsley Wolf M.D.		23b. ADDRESS 721 Olive St. St. Louis Mo		23c. DATE SIGNED 12-18-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 20, 1954		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			

DATE REC'D BY LOCAL REG. DEC 20 1954		REGISTRAR'S SIGNATURE Paul Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wanda Johnson 6175 Delmar S.E.L.	
------------------------------------------------	--	-------------------------------------------------	--	-------------------------------------------------------------------------------------	--

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

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 *Jos. E. McCulloh*.....

Licensed Embalmer No... 246.....

P. O. Address... 6175 De.....

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.