

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39315**

FILED DEC 13 1955

BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>500</b>		Registrar's No. <b>2792</b>				
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>				b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town) <b>Koch, Mo</b>		c. LENGTH OF STAY (in this place) <b>2 days</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>1908 N. 14th</b>				<b>2269</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Goldman</b>			b. (Middle) <b>(None)</b>		c. (Last) <b>Mc Clanahan</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11-27-55</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>		8. DATE OF BIRTH <b>11-20-1900</b>		9. AGE (In years last birthday) <b>55</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah Williams</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Records Koch Hospital, Koch, Mo.</b>			ADDRESS _____		
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, asthenia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>Alcoholism, Cirrhosis of liver, Malnutrition, Cryptorchism</b>						20. INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						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) _____		21d. (COUNTY) _____		21e. (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? _____						
22. I hereby certify that I attended the deceased from <b>11-25</b> , 19 <b>55</b> to <b>11-27</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>11-26-55</b> , and that death occurred at <b>12:15am</b> from the causes and on the date stated above.										
23a. SIGNATURE <b>H.A. Harris</b> (Degree or title) <b>MD</b>				23b. ADDRESS <b>Robert Koch Hosp., Koch, Mo</b>			23c. DATE SIGNED <b>11-28-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Nov. 30-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>				
DATE REC'D BY LOCAL REG. <b>11-30-55</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Dombard</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Leidner Und, Co.</b>					ADDRESS <b>2223 St. Louis Ave.</b>	

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 Not Embalmed, Student Embalmer No. \_\_\_\_\_ working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John P. Buckholz  
Licensed Embalmer No. 167

P. O. Address 2223 Sol

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.