

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2740

FILED JAN 29 1957

State File No. ....

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 331

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>01 3102<sup>A</sup> CHEROKEE ST 1670 3102<sup>A</sup> CHEROKEE ST</b>		e. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED a. (First) <b>JOHN</b> (Type or Print) b. (Middle) <b>W</b> c. (Last) <b>GOELZ</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JAN 9 1957</b>	
5. SEX <b>0</b> <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. MARRIED, NEVER MARRIED, 2 WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JAN 6 1891</b>
9. AGE (In years last birthday) <b>66</b>		10. AGE (In years) IF UNDER 1 YEAR IF UNDER 4 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MAINTENANCE MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CARTER DUSTRY</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>0</b> <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>	
13a. FATHER'S NAME <b>JOHN W GOELZ SR</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA KOLAJA</b>	
14. NAME OF HUSBAND OR WIFE <b>ANNA GOELZ (Dec'd)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WORLD WAR I 489-03-1030</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>RAYMOND GOELZ</b>		ADDRESS <b>5104 EXETER</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Atherosclerotic Heart Disease</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 Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertension 420.0</b>	
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>	
20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE HOMICIDE <b>None</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>None</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>None</b>			
22. I hereby certify that I attended the deceased from <b>6-2</b> , 1953, to <b>1-10</b> , 1957, that I last saw the deceased alive on <b>1-2</b> , 1957, and that death occurred at <b>11A</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Harry J. Heidenreich M.D.</b>		23b. ADDRESS <b>3750 Gravois St. St. Louis, Mo.</b>	
23c. DATE SIGNED <b>1-11-1957</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JAN 12-1957</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>NEW ST MARCUS CEM</b>		24d. LOCATION (City, town, or county) (State) <b>ST LOUIS MO</b>	
DATE REC'D BY LOCAL REG. <b>JAN 11 57</b>		REGISTRAR'S SIGNATURE <b>E. Carl Smith MO</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kutis</b>		ADDRESS <b>2906 Gravois</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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Leaf Budd*  
Licensed Embalmer No. *398*

P. O. Address *St. Louis*

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.