

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011669  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2512**

300

-57

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>01 4487 Lindell</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>4487 Lindell</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>EDWARD FIELD GOLTRA Jr.</b>			4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5 1890</b>		9. AGE (In years last birthday) <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Edward Field Goltra</b>		13b. MOTHER'S MAIDEN NAME <b>Kate Brown.</b>		14. NAME OF HUSBAND OR WIFE <b>Elizabeth Hoff Goltra</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give type or dates of service) <b>Yes W.W.I.</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Goltra 4487 Lindell St., Louis Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) <b>Coronary heart disease associated</b>					<b>several years.</b>
DUE TO (c) <b>with arterio-sclerotic heart disease.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.1</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>1955</b> to <b>3/2/58</b> and last saw her alive on <b>3/2/58</b> Death occurred at <b>11:15</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Thomas C. Bondaree M.D.</b>			22b. ADDRESS <b>4660 Maryland Ave</b>		22c. DATE SIGNED <b>3/2/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE <b>3/4/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Diamond Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jacksonville Illinois</b>
24. FUNERAL DIRECTOR <b>C.R. Lupton and Sons 7233 Delmar</b>			25. DATE RECD. BY LOCAL REG. <b>MAR 3 58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doc., Coroner, etc. must use only standard rubrications in Part 18. No symptoms or signs related. All diseases in Part I must be causally related.

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 *Clarence H. Mur*.....

Licensed Embalmer No. *4011*.....  
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.