

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019724
STATE FILE NUMBER
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5748

FILED JUN 11 1958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4745 Cupples	
3. NAME OF DECEASED (Type or print) First Middle Last Leslie Goss		4. DATE OF DEATH Month Day Year 5 31 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Private Homes	11. BIRTHPLACE (City and state or country) Haywood County, Tenn.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Bill Goss	
13b. MOTHER'S MAIDEN NAME Carston Thias		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 494-01-5097	
17. INFORMANT Address Mr. Ralieggh Granberry 4745 Cupple			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>420.0</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Congene both feet (Phad AK Amputation)</i>			INTERVAL BETWEEN ONSET AND DEATH undet.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 5-8-58 to 5-31-58 and last saw ^{him} alive on 5-31-58 Death occurred at 7:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE <i>James M. Allison Jr.</i> (Degree or title) M.D.		21b. ADDRESS 2601 Whittier Street	
21c. DATE SIGNED 6-2-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/4/58	
23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR G. Wade Granberry 4202 Finney Ave.		25. DATE RECD. BY LOCAL REG. JUN 3 '58	
26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> M. J. B.			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Edward G Flynn*

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave

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.