

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026983
STATE FILE NUMBER
6623

FILED JUL 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp.		Length of stay in lb 38 yrs.	d. STREET ADDRESS (If outside, give location) 3614 Indiana Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE LAST JOSEPH NICHOLAS GODEFROID			4. DATE OF DEATH Month Day Year June 30, 1958		
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1899	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) Manchester, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Mathias Godefroid		13b. MOTHER'S MAIDEN NAME Maria Margaret Fuchs		14. NAME OF HUSBAND OR WIFE Mrs. Della Godefroid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. No. 1		16. SOCIAL SECURITY NO. 500-42-0338	17. INFORMANT Address Mrs. Della Godefroid, 3614 Indiana		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 420.1
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>4:05 P.M.</u> to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Patrick E. Taylor Coroner</u> (Degree or title)			22b. ADDRESS <u>1500 Clark</u>		22c. DATE SIGNED <u>7.2.58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 3, 1958	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) St. Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR ADDRESS Beiderwieden F.H. Inc. 1936 St. Louis			25. DATE RECD. BY LOCAL REG. JUL 2 '58	26. REGISTRAR'S SIGNATURE <u>Carl Smith Mo</u> m86	

All diseases in Part I must be causally related.

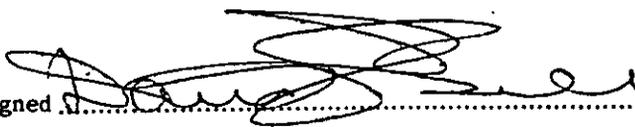
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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  _____

Licensed Embalmer No. 4520

P. O. Address Laurel

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.