

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041615

STATE FILE NUMBER

318

1003

10373

Registration District No. _____ Primary Registration District No. _____ Registered _____

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY _____

b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits
OR TOWN St. Louis Yes No

c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb
HOSPITAL OR INSTITUTION City Hospital D.O.A. 39

d. STREET ADDRESS (If outside, give location) Reside on Farm
2759 Tamm Ave. Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
ADA MAE GODI

4. DATE OF DEATH Month Day Year
Oct. 27 1958

5. SEX Female 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH May 8, 1913

9. AGE (In years last birthday) 45 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
11. BIRTHPLACE (City and state or country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Herman Kuhnert 13b. MOTHER'S MAIDEN NAME Kate Caffrey 14. NAME OF HUSBAND OR WIFE Thomas A. Godi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address Thomas A. Godi 2759 Tamm Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES NO 2

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 _____ to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Taylor Coroner 3 22b. ADDRESS 1300 Clark 22c. DATE SIGNED 10 29 58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE Oct. 31, 1958 23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S.Kingshighway 25. DATE RECD. BY LOCAL REG. OCT 29 58 26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

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 William B. White

Licensed Embalmer No. 1291

P. O. Address 12282 Kingsley

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.