Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002979 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 135

FILED JAN 26 1959

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 2567 W. Dodier St. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2567 W. Dodier St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Goeke
4. DATE OF DEATH Month 1 Day 4 Year 59
5. SEX F.
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec 5th 1896
9. AGE (In years last birthday) 62 — 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) Retired
10b. KIND OF BUSINESS OR INDUSTRY Rexall Dreug
11. BIRTHPLACE (City and state or country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Henry Goeke
13b. MOTHER'S MAIDEN NAME Mary Kreamer
14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. (unk)
17. INFORMANT Miss Anna E. Goeke — Address 2567 W. Dodier

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 332x
INTERVAL BETWEEN ONSET AND DEATH
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 ☐

MEDICAL CERTIFICATION

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 a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ 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 859 A 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 (Decedent's Attn) Joseph M. Quinn — 22b. ADDRESS 1300 Clark — 22c. DATE SIGNED 1/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1/7/59
23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemet.
23d. LOCATION (City, town, or county) St Louis Mo. (State)

24. FUNERAL DIRECTOR Robert D. Kinealy — ADDRESS 2228 St. Louis Ave.
25. DATE REC'D BY LOCAL REG. JAN 6 59
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address Gloversville

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.