Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002980
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 743

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN East St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Peoples — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1505 S. "J" Street — Reside on Farm Yes [ ] No [X]

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3. NAME OF DECEASED (Type or print) First JOHN Middle Last GOHANNA		4. DATE OF DEATH Month Jan. Day 19, Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH 6/24/1898
9. AGE (In years last birthday) 60	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Armour & Co.	11. BIRTHPLACE (City and state or country) One Lock, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME NELSON GOHANNA	13b. MOTHER'S MAIDEN NAME ROSE MORRIS	14. NAME OF HUSBAND OR WIFE Sallie Gohanna	
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. 327-03-3131	17. INFORMANT Sallie Gohanna Address 1505 S. "J" St. E. St. Louis, Ill.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hypostatic Pneumonia	4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Pulmonary Edema	1 week
DUE TO (c)	Pleurisy c̄ Effusion	4 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 003.1

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

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 12-16-58, to 1-18-59 and last saw ~~her~~ him alive on 1-18-59
Death occurred at 630 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. A. Fingal M.D.	22b. ADDRESS 1652 Central Ave. E St Louis, Ill	22c. DATE SIGNED 1-22-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/25/59	23c. NAME OF CEMETERY OR CREMATORY Booker Washington
23d. LOCATION (City, town, or county) (State) Centreville Township, Ill.		
24. FUNERAL DIRECTOR Marion E. Office ADDRESS 2114 Mo. Ave. E. St. Louis, Ill.	25. DATE RECD. BY LOCAL REG. JAN 22 '59	26. REGISTRAR'S SIGNATURE Earl Smith MD MCB

(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 Frank Pronoff

Licensed Embalmer No. 4356

P. O. Address St Louis Mo

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.