Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002986
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 795

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY St. Clair
c. CITY OR TOWN Washington Park — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 5732 Warren (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Sterhen Middle: Last: Gotch
4. DATE OF DEATH Month: Jan. Day: 22 Year: 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 12, 1902
9. AGE (In years last birthday) 56 — 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) Steam Fitter
10b. KIND OF BUSINESS OR INDUSTRY Refrigeration
11. BIRTHPLACE (City and state or country) Belleville, Ill.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Lawrence Gotch
13b. MOTHER'S MAIDEN NAME Pearl Hathwski
14. NAME OF HUSBAND OR WIFE Ida May Gotch
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 248 05 2830
17. INFORMANT Ida May Gotch Address 5732 Warren E. St Louis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Essential hypertension	10 yrs. ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Chronic Renal Failure	Unknown
	~~Chronic Glomerular-NephroSclerosis~~	"
	Pyelonephritis 592X	1 mon.
DUE TO (b)		

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 ☐

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 Jan. 7, 1959, to Jan. 22, 59 and last saw him alive on Jan. 22/59
Death occurred at 4:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M.D.
22b. ADDRESS 4145a S. Grand Ave
22c. DATE SIGNED Jan. 23, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Jan. 24, 1959
23c. NAME OF CEMETERY OR CREMATORY Green Mount
23d. LOCATION (City, town, or county) (State) Belleville Ill

24. FUNERAL DIRECTOR Chas M. Burke ADDRESS East St. Louis, Ill
25. DATE RECD. BY LOCAL REG. JAN 23 '59
26. REGISTRAR'S SIGNATURE Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Chas. M. Burke

Licensed Embalmer No. 2421

P. O. Address East St. Louis, I

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.