

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007145

STATE FILE NUMBER
1463

FILED FEB 26 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

300
-57

81

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) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Length of stay in 1b 1 1/2 yrs.	d. STREET ADDRESS (If outside, give location) 3726 California
3. NAME OF DECEASED (Type or print) First Middle Last Johanna Gordon			4. DATE OF DEATH Month Day Year 2-10-59
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 20 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81
11. BIRTHPLACE (City and state or country) Mo.		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME -Michael OBrien		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE David (Deceased)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT John Ries 3726 California 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) <i>Meningioma</i>			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 223X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Generalized arteriosclerosis - 1 1/2 yrs.</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 WORK <input type="checkbox"/> NOT WHILE 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 7-25-57 to 2-10-59 and last saw her/him alive on 2-10-59 Death occurred at 5:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED <i>2/10/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/13/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St Louis Missouri
24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. FEB 11 59	26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed George J. Svoboda Jr......
Licensed Embalmer No. 4899.....
P. O. Address 1926 Allen.....

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.