

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-021962

FILED JUL 13 1959

Registration District No. _____ Primary Registration District No. 4249 Registrar's No. 43

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jefferson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence Before admission) a. STATE Mo. b. COUNTY Jefferson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hillsboro		Length of stay in 1b 6 Months		c. CITY OR TOWN House Springs		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Castle Acres Nursing			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.R.#2 Box 45		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle L. Last GOFF				4. DATE OF DEATH Month July Day 3 Year 1959				
5. SEX Male	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 8-31-1870	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Worker (Retired)			10b. KIND OF BUSINESS OR INDUSTRY Ganahl Dairy Co.		11. BIRTHPLACE (City and state or country) St. James, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Delfred Carpentier			13b. MOTHER'S MAIDEN NAME Unknown Williamson			14. NAME OF HUSBAND OR WIFE Late Emma Jane Goff		
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. None		17. INFORMANT House Springs, Mo. Tony D. Goff R.R.#2-Box 45				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. arterio sclerosis DUE TO (b) C. arterio sclerotic cardio DUE TO (c) vascular renal disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.) no.						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 July 1, 1959 to July 3, 1959 and last saw him alive on July 1, 1959 Death occurred at 3:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Paul V. Hoffmeister M.D.				22b. ADDRESS Robert Mo.		22c. DATE SIGNED July 3, 1959		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Mtr)	23b. DATE July 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Wash Cemetery		23d. LOCATION (City, town, or county) St. James, Mo.				
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S.Kingshighway			25. DATE RECD. BY LOCAL REG. July 3, 1959		26. REGISTRAR'S SIGNATURE Walter B. ...			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 C I 70F

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. W. Storrard

Licensed Embalmer No. 4007

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.