

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026683

FILED VS AUG 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7119** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO		a. STATE Mo	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LITTLE SISTERS POOR		c. CITY OR TOWN ST. LOUIS MO	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in lb		d. STREET ADDRESS (If outside, give location) 2614⁹ OREGON	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	CHARLES		GODAIRE	JULY 29 1959			

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH DEC. 13 1882	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOOK BINDER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mo	12. CITIZEN OF WHAT COUNTRY U-S-A.
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13a. FATHER'S NAME JOSEPH GODAIRE	13b. MOTHER'S MAIDEN-NAME MARY BAUMANN	14. NAME OF HUSBAND OR WIFE
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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 PHILIP K. NESTMANN	Address 2614⁹ OREGON
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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)	Arteriosclerotic Heart Disease	yes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Arteriosclerosis	yes
	DUE TO (c) 420.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 St. Louis, Mo	COUNTY	STATE
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21. I attended the deceased from **Jan 1959** to **7/29/59** and last saw him alive on **7/24/59**.
Death occurred at **12:30 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Thomas R. Watson M.D.	(Degree or title)	22b. ADDRESS 8059 WATSON RD.	22c. DATE SIGNED 7/31/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE AUG. 3 1959	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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24. FUNERAL DIRECTOR Thomas R. Watson	ADDRESS 2906 Leavis	25. DATE RECD. BY LOCAL REG. AUG 1 '59	26. REGISTRAR'S SIGNATURE Loard Smith, H.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

8.63

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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