

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027431

FILED VS AUG 1 0 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2082 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>St. Louis</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>21 hrs.</u>	c. CITY OR TOWN <u>Bel Ridge</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3505 Carson Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DAN</u> Middle <u>GOLDBECK</u> Last <u>GOLDBECK</u>	4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1959</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-39</u>	9. AGE (last birthday) <u>19</u>	IF UNDER 1 YEAR Months <u>19</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Bread Wrapper</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Sylvester Goldbeck</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Rose McCulley</u>	14. NAME OF HUSBAND OR WIFE <u>Jean Goldbeck</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>486-40-2550</u>	17. INFORMANT <u>Jean Goldbeck, 3505 Carson Rd.</u>
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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: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>	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
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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 _____ 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 COUNTY STATE
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21: I attended the deceased from 8-1-1959 to 8-2-1959 and last saw her/him alive on 8-2-1959  
Death occurred at 12:45 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul W. Schaper M.D.</u>	22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED <u>8/3/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery, Florissant, Mo.</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann, Mo.</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>8-3-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Sheldon Collier

Licensed Embalmer No. 3580

P. O. Address St. Ann

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