

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030128

FILED VS SEP 8 1959

STATE FILE NUMBER

Registration District No. 910 Primary Registration District No. 3058 Registrar's No. 200

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CHARLES</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		Length of stay in 1b <u>33 YRS</u>		c. CITY OR TOWN <u>ST. CHARLES</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>2225 CHERRY LANE</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2225 CHERRY LANE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>BERNIECE</u> Middle <u>C.</u> Last <u>GOELLNER</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>24</u> Year <u>1959</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</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>SEPT. 27, 1923</u>	9. AGE (last birthday) <u>35</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>28</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>IN OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>STEPHEN DUNN</u>			13b. MOTHER'S MAIDEN NAME <u>CATHERINE KRUETZER</u>			14. NAME OF HUSBAND OR WIFE <u>ROBERT L. GOELLNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.II</u>			16. SOCIAL SECURITY NO. <u>489-22-2652</u>		17. INFORMANT <u>ROBERT L. GOELLNER, ST. CHARLES MO</u>			Address	
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>Metastatic Carcinoma</u> <u>Carcinoma of breast</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>15 mo</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5 month pregnancy</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" 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.)							
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u>									
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 <u>8/00 1952</u> to <u>August 1959</u> and last saw her alive on <u>8-24-59</u> Death occurred at <u>8 00</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Wm H Poggemeier M.D.</u> (Degree or title)				22b. ADDRESS <u>St Charles, Mo.</u>				22c. DATE SIGNED <u>Sept 26, 1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>AUG. 27, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. CHARLES BORROMEIO CEM</u>			23d. LOCATION (City, town, or county) (State) <u>ST. CHARLES Mo.</u>			
24. FUNERAL DIRECTOR <u>C. L. PRINSTER, ST. CHARLES, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>AUG 27-59</u>		26. REGISTRAR'S SIGNATURE <u>Marella Wilson</u>				

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 Howard O. Kessler

Licensed Embalmer No. 4631

P. O. Address Wentzville

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.