

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040696

FILED VS. NOV. 3 0 1959

4249

86

STATE FILE NUMBER

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

ENDED

| | | | | | | | | |
|--|--|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Jefferson | | | | 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 Hillsboro | | Length of stay in 1b 1 week | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Cedar Grove Nurs. Home | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (if outside, give location) 4215 Pleasant St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Viola Middle _____ Last Godt | | | | 4. DATE OF DEATH Month Nov. Day 21 Year 1959 | | | | |
| 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 11/30/1889 | 9. AGE (last birthday) 70 | 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) housework | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (City and state or county) St. Louis Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME William Eilman | | | 13b. MOTHER'S MAIDEN NAME Margaret Fridel | | 14. NAME OF HUSBAND OR WIFE Edward Godt | | | |
| 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 Edward Godt | | | Address 2434 Akins Dr. | |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i> | | |
| 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) | | | | | 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.) | | | | | | |
| 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 <i>Nov 2, 1959</i> to <i>Nov 21, 1959</i> and last saw her was ^{her} alive on <i>Nov 15, 1959</i> Death occurred at _____ <i>9130A</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>Robert D. Sankus, M.D.</i> (Doctor or title) | | | | 22b. ADDRESS <i>1502 Cass Av</i> | | 22c. DATE SIGNED <i>11-23-59</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 11-24-1959 | 23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery | | 23d. LOCATION (City, town, or county) St. Louis Mo. | | (State) | | |
| 24. FUNERAL DIRECTOR Buchholz Mort. 5967 W. Florissant Av. | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. 11-25-59 | 26. REGISTRAR'S SIGNATURE <i>Walter R. ...</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 2 1956

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

Student _____
Signature of Student Embalmer

Signed

Wilfred H. Buchholz

Licensed Embalmer No.

4551

P. O. Address

St. Louis

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.