

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041879

XC 20703232 SL 16185 FILED VS DEC 11 1959

211025

STATE FILE NUMBER

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

UNDECEASED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 157 DAYS	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 VET ADM HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2847 MAGNOLIA STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last FRED CHARLES GOEKE			4. DATE OF DEATH Month Day Year NOVEMBER 28, 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-12-97	9. AGE (last birthday) 62	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY Strecker Transfer Co.	11. BIRTHPLACE (City and state or country) ST. LOUIS CO., MO.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME FRED GOEKE		13b. MOTHER'S MAIDEN NAME MILLY WARMANN		14. NAME OF HUSBAND OR WIFE Frances Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 497-05-3893	17. INFORMANT Address VA HOSP REC. ST. LOUIS, MO.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM PHARYNX		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) CARCINOMA OF HYPOPHARYNX		3 YEARS
DUE TO (c) 147x		
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 s.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 **6-24-59** to **11-28-59** and last saw ~~him~~ ^{her} alive on **11-28-59**
Death occurred at **10:40 p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>William H. Gosbald</i> M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 11-29-59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE DEC. 2, 1959	23c. NAME OF CEMETERY OR CREMATORY NEW BETHLEHEM, CEMETERY
23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MISSOURI		

24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F. H. INC. 1936 ST. LOUIS AVE.	25. DATE RECD. BY LOCAL REG. NOV 30 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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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 Homer H. Tri

Licensed Embalmer No. 3882

P. O. Address St. Lou

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.