

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 5 1960

2 834 -60-003449  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>INCARNATE WORD HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3449 Macklind</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>-</b> Last <b>GOEKE</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>24</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-24-60</b>		9. AGE (last birthday) <b>1</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Ralph Frank Goeke</b>			13b. MOTHER'S MAIDEN NAME <b>Rose Marie Gertken</b>			14. NAME OF HUSBAND OR WIFE <b>-</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mrs. Ralph Goeke</b>			Address <b>Same.</b>	
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>Acetabasis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour 4 min</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Premature separation placenta</u>					? hours		
		DUE TO (c) <u>Premature rupture membranes</u>					5 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>mother habitual aborter -</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			
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 <u>1-24-60</u> to <u>1-24-60</u> and last saw him alive on <u>1-24-60</u> Death occurred at <u>7:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. H. Kusler</u> (Degree or title)				22b. ADDRESS <u>1525 So Grand</u>			22c. DATE SIGNED <u>1-24-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan..26,1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>5239 W. Florrisant ave.</b>		(State)	
24. FUNERAL DIRECTOR <b>C. Hoelmeister</b> 6464 Chippewa St.				ADDRESS <b>Colonial Mortuary</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 25 1960</b>		26. REGISTRAR'S SIGNATURE <u>Joan Smith. M.D.</u> mjc	

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 Lewis C. Hoff

Xr

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.