

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012628

FILED VS APR 5 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3239** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		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 ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOSP.		d. STREET ADDRESS (If outside, give location) 3663 LIERMAN	

3. NAME OF DECEASED (Type or print) First Middle Last AMANDA GOGEL			4. DATE OF DEATH Month Day Year MARCH 18 1960			
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 MAY 31 1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U-S-A
13a. FATHER'S NAME JOHN THEIN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE ANTHONY GOGEL (Dfcd)		
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 Address ALOIS GOGEL 3400 TAFT AVE.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO (b) Hypertension		
DUE TO (c) 334x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)	
20c. TIME OF INJURY Hour Month, Day, Year 11:00 AM 3-18-60			
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 **8-26-48** to **3-18-60** and last saw her ^{her} alive on **3-18-60**
Death occurred at **7:35 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. J. Meyers M.D. (Degree or title)	22b. ADDRESS 5507 Poloma	22c. DATE SIGNED 3-21-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR 23 1960	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 21 1960	26. REGISTRAR'S SIGNATURE Kearl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

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 Eleonora Province

Licensed Embalmer No. 3403

P. O. Address 2906 Row

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