

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012631

FILED VS MAR 3 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3287** STATE FILE NUMBER

INDEXED

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, Missouri		Length of stay in 1b 4 mos. 26 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 St. Louis State Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4462 Lexington Av.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle G. Last GOOLD			4. DATE OF DEATH Month March Day 20th Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-30-92	9. AGE (last birthday) 67 yrs.	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) formerly: bottler		10b. KIND OF BUSINESS OR INDUSTRY Beer		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Robert Goold			13b. MOTHER'S MAIDEN NAME Ione (Leader)		14. NAME OF HUSBAND OR WIFE Wife: Hester Goold		
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. Unk.		17. INFORMANT Address Mrs. Hester Goold, 4462 Lexington			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral virus pneumonitis						INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bacterial bronchopneumonia, bilateral							
DUE TO (c) Generalized arteriosclerosis							
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 checked="" type="checkbox"/> NO <input 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 Oct. 23, 1959 , to March 20, 1960 and last saw ^{her} him alive on March 20, 1960 Death occurred at L. Horstatter, M.D. 7:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>L. Horstatter M.D.</i>				22b. ADDRESS 5400 Arsenal St.		22c. DATE SIGNED 3-21-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 3/24/60	23c. NAME OF CEMETERY OR CREMATORY Walnut Hill Cemetery		23d. LOCATION (City, town, or county) Belleville		STATE Ill.	
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral, 1905 Union Blvd.			25. DATE RECD. BY LOCAL REG. MAR 22 1960		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

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

Warren A. Co

Licensed Embalmer No. 353

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.