

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024531

FILED VS JUL 15 1960

318

Primary Registration District No. 1003

Registrar's No. 6594

STATE FILE NUMBER

INDEXED

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, MISSOURI			Length of stay in 1b		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 BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 725 S. Skinker Blvd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOUIS Middle NMN Last GOULD			4. DATE OF DEATH Month JUNE Day 28 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 1/21/90	9. AGE (last birthday) 70	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). Chairman of the Board			10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Samuel Gould			13b. MOTHER'S MAIDEN NAME Yetta Lederhandler		14. NAME OF HUSBAND OR WIFE Rose Lasky Gould		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.			16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Address Mrs. Rose L. Gould-725 S. Skinker			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) STAPHYLOCOCCAL SEPTICEMIA						2 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PNEUMONITIS						2 WEEKS	
DUE TO (c) DIABETES MELLITUS						15 YEARS	
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 DEC. 14, 1959 to JUNE 28, 1960 and last saw her/him alive on JUNE 28, 1960 Death occurred at 4:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) F.R. Bradley F. R. BRADLEY, M.D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 6/29/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/30/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf, Inc. 5216 Delmar			25. DATE RECD. BY LOCAL REG. JUN 29 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mrs. Rose L. Goid-752 P. Kinkner
 2101 York Road
 St. Louis, Missouri 63114

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 John Ketter
 Licensed Embalmer No. 3880

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.

RETURN TO: MISSOURI BOARD OF HEALTH, ST. LOUIS, MISSOURI