

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS,</b>		a. STATE <b>MISSOURI</b> b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6211 SCANLON AVE</b>		c. CITY OR TOWN <b>ST LOUIS,</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6211 SCANLON AVE</b>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>B.</b> Last <b>GOACHER</b>	4. DATE OF DEATH Month <b>SEPT,</b> Day <b>27,</b> Year <b>1960</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/1885</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JACOB GOACHER</b>	13b. MOTHER'S MAIDEN NAME <b>LEAH BOURLAND</b>	14. NAME OF HUSBAND OR WIFE <b>ELLA GOACHER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>ELLA GOACHER 6211 SCANLON AVE</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>331x</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertension</b>	
	DUE TO (c)	
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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 <b>ST LOUIS</b>	COUNTY <b>MO.</b>	STATE
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21. I attended the deceased from **March 5-52** and last saw him alive on **Sept 17-60**  
 Death occurred at **3 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Elmer E Syton M.D.</b>	(Degree or title)	22b. ADDRESS <b>Arcade Bldg.</b>	22c. DATE SIGNED <b>9-28-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>6/30/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE CEMETERY</b>	23d. LOCATION (City, town or county) <b>ST LOUIS COUNTY MO.</b>
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24. FUNERAL DIRECTOR <b>STROOT - CARROLL 4600 NATURAL BRIDGE</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 29 1960</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

~~Handwritten notes and scribbles at the top of the page, including the word 'Facts' and some illegible characters.~~

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed M W Ruter

Licensed Embalmer No. 4865  
P. O. Address St Louis, Mo

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