

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 5 1961 317

-60-048218  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 546 Registrar's No. 3747

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland, Mo</u>		c. CITY OR TOWN <u>Cantwell, Mo</u>	
Length of stay in 1b _____		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If outside, give location) _____	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle _____ Last <u>Gott</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>18</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26 1884</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House-Wife</u>		11. BIRTHPLACE (City and state or country) <u>Spencer Station Ky. U.S.A.</u>	

12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Richards Connors</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Hanks</u>		14. NAME OF HUSBAND OR WIFE <u>Alfred Gott Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. George Gott Columbia, Mo</u>			

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 <u>1-2 hrs</u>
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>			
DUE TO (b) <u>Arteriosclerotic heart disease</u>			
DUE TO (c) _____			unknown
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 checked="" 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 _____
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21. I attended the deceased from Nov 18, 1960 to Dec 18 '60 and last saw her/him alive on Dec 18, 1960  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. L. Foster MS</u> (Degree or title)	22b. ADDRESS <u>Desloge, Mo</u>	22c. DATE SIGNED <u>Dec 20/1960</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-21-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wood-Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Leadington, Mo</u>
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24. FUNERAL DIRECTOR <u>R. Caldwell &amp; Sons Flat River, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-27-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. [Signature]</u>
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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 Donald Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River, Mo

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.