

AMENDED

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 ST. LOUIS, MISSOURI		c. CITY OR TOWN Pekin	
Length of stay in lb		d. STREET ADDRESS (If outside, give location)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		1109 South Fifth St.,	

3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK JAMES GOGELE			4. DATE OF DEATH Month Day Year JANUARY 27 1961		
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 1/15/1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY American Distillery	11. BIRTHPLACE (City and state or country) Peoria, Illinois.	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Greger Gogele	13b. MOTHER'S MAIDEN NAME Magdalen Fetzer	14. NAME OF HUSBAND OR WIFE Ethel Gogele
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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) No	16. SOCIAL SECURITY NO. Nil	17. INFORMANT Address Ethel Gogele, 1109 South Fifth Street., Pekin, Illinois.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) LEFT SUBPHRENIA ABSCESS		1 WEEK
DUE TO (b) POST-OPERATIVE TOTAL GASTRECTOMY		10 DAYS
DUE TO (c) RETICULUM CELL SARCOMA OF STOMACH		1 YEAR

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		200.0	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
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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.)
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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 JAN. 9, 1961 to JAN. 27, 1961 and last saw her alive on JAN. 27, 1961	
Death occurred at 10:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <i>E. J. Conillian, M.D.</i> (Degree or title)	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/28/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/30/61	23c. NAME OF CEMETERY OR CREMATORY Chippewa Cemetery	23d. LOCATION (City, town, or county) Rock Island, Illinois.
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24. FUNERAL DIRECTOR Noel Funeral Home, Pekin, Illinois.	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Lawrence B. [unclear]
NO EMBALM

Licensed Embalmer No. _____

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.