

C 15 1938

DEC'D JAN 6 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

44419
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township Clayton Primary Registration District No. 181 Registered No. 2049
 (c) City Clayton (d) Street No. St. Louis County Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kenneth Ronald Goggin
 (a) Residence, No. 6309 Julian, Wellston, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10/15/38

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 1 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Clayton (STATE OR COUNTRY) Mo.

FATHER 13. NAME Orvall Goggin

14. BIRTHPLACE (CITY OR TOWN) ? (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Sophie Dawson

16. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY)

17. INFORMANT father, Orvall Goggin (ADDRESS) 6309 Julian, Wellston, Mo.

18. BURIAL, CREMATION, OR REMOVAL Clear Springs Cem. PLACE Van Buren, Mo. DATE 12-16-1938

19. FUNERAL DIRECTOR (NAME) Jos. W. Clark (ADDRESS) 1125 Hodiamont

20. FILED DEC 15 1938 J. R. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/14/38 19

22. I HEREBY CERTIFY, That I attended deceased from 10/15/38 to 12/14/38, 19

I last saw him alive on 12/14/38, 19. Death is said to have occurred on the date stated above, at 8:55 P. M.

The principal cause of death and related causes of importance were as follows:

Hydrocephalus ✓

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify: L. M. Cronhey, M. D.
 (Address) Co. Arp.

Date of onset

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1572

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

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 this body is not embalmed, above space should be left blank.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

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1. PLACE OF DEATH (a) County St. Louis (b) Township Clayton (c) City Clayton (d) Street No. (e) Length of residence in city or town where death occurred (f) How long in U.S., if of foreign birth? (g) How long in U.S., if of foreign birth? (h) How long in U.S., if of foreign birth? 2. PRINT FULL NAME (a) Residence, No. (Usual place of abode, if no street address, write county or city) St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS 3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 13. NAME 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 15. MAIDEN NAME 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 17. INFORMANT (ADDRESS) 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19. FUNERAL DIRECTOR (ADDRESS) 20. FILED 19

MEDICAL CERTIFICATE OF DEATH 21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-14 1938 22. I HEREBY CERTIFY, That I attended deceased from 19 to 19 I last saw h. alive on 19. Death is said to have occurred on the date stated above, at m. The principal cause of death and related causes of importance were as follows: Hydrocephalus (Congenital) Date of onset 10-15-38 Other contributory causes of importance: 1574 Name of operation Date of What test confirmed diagnosis? Was there an autopsy? 23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19 Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. Manner of injury Nature of injury 24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) L M Acordy, M. D. (Address) Co Hoop

SUPPLEMENTARY

Local Registrar.

