

REC'D MAR 13 1939

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

5017
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1008**
 (c) City **St Louis** (d) Street No. **4929 Claxton Ave** 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

630 **Lena Goewert**
 (a) Residence, No. **4929 Claxton Ave** St. **7** (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 Female | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF August Goewerth ✓ | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 11 1863 | | |
| 7. AGE | YEARS 75 | MONTHS 10 |
| | DAYS 11 | If LESS than 1 day, hrs. or min. |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home | 11. Total time (years) spent in this occupation |
| | 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) | |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany | | |
| FATHER | 13. NAME Fritz Schlingmann | |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany | |
| MOTHER | 15. MAIDEN NAME Unknown | |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown | |
| 17. INFORMANT (ADDRESS) Mrs. Goewert, 4929 Claxton Ave | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE New Bethlehem Cem DATE Feb 25 1939 | | |
| 19. FUNERAL DIRECTOR (ADDRESS) Beiderwieden Funeral Home Inc 1936 St. Louis Ave | | |
| 20. FILED FEB 23 1939 J. D. Budick Local Registrar | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb 22 1939** 19

22. I HEREBY CERTIFY, That I attended deceased from **February 5, 1939** to **February 22, 1939**
 I last saw her alive on **February 22, 1939** Death is said to have occurred on the date stated above, at **11:15 A.M.**
 The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis
 Date of onset **2-1-36**

Other contributory causes of importance:
Carcinoma of gall bladder 7-1-38

Name of operation **None** Date of _____
 What test confirmed diagnosis? **Clinical** Was there an autopsy? **No**

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? **No**
 If so, specify _____
 (Signed) **Almued Burns** M. D.
 (Address) **362 N. Grand Blvd**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

1-112604

STATEMENT BY LICENSED EMBALMER

I, *Lucretia*, Licensed Embalmer No. *3737*

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

No. *L. P.* or by *Torou Percy*, Registered Apprentice No. *141*

working under my personal supervision.

Signed *Lucretia*
Licensed Embalmer No. *3737*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

AMERICAN BOARD OF FUNERAL DIRECTORS
REGISTERED EMBALMER
STATE OF MISSISSIPPI

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

5017
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
 (b) Township St. Louis Primary Registration District No. 10.23 Registered No. 1710
 (c) City St. Louis (d) Street No. 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 Lena Goewert

(a) Residence, No. 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
75 10 11

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)

FATHER 13. NAME

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

MOTHER 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 3/30/39 1939

J. B. Bealeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2. 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from

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:

Date of onset

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.....

(Signed) R. Emmett Byrnes, M. D.

(Address) 3802 N Grand Blvd

N. B. Every item of information should be carefully supplied. AGE should be stated FULLY. 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.

