

FILED OCT 12 1945

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 8527

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Bert Gothard

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Josephine Gothard

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased: August 8, 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>1</u>	<u>22</u>	hr. _____ min.

9. Birthplace: _____
(City, town, or county) (State or foreign country)

Ohio

10. Usual occupation Retired

MOTHER FATHER

11. Industry or business _____

12. Name Don't Know

13. Birthplace Don't Know
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Josephine Gothard

(b) Address 1039 Allen Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Oct. 3, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand St.

19. (a) OCT 2 1945
(Date received local registrar)

J. F. Medsker
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1039 Allen Ave.
(If rural, give location)

(e) Citizen of foreign country? _____
(Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1945 hour 7 minute 15 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Sclerosis

Due to: Intercerebral

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

JHA

Major findings: _____

Of operations: _____

Of autopsy: _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

(Specify type of place) _____

(e) Means of injury 3
Patrol & Taylor's Dep Car
(M. O. or other)

23. Signature J. F. Medsker

Address 1300 Ward Ave Date signed 10-2-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

10
7
9

1549

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.....

Wm. A. Stewart

Licensed Embalmer No..... 3722

P. O. Address..... 412 Duchouquette St.

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, fact should be so stated above.