

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3500**  
Registrar's No. **142**

Registration District No. **277**

Primary Registration District No. **3069**

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

1. PLACE OF DEATH:

(a) County **MISSOURI, Richmond Heights**

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

(c) Name of hospital or institution:  
**ST. MARY'S HOSPITAL**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 DAY**  
(Specify whether **0**)

In this community \_\_\_\_\_  
years, months or days

USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **96**

(c) City or town **ST. LOUIS**  
(If outside city or town limits, write "RURAL")

(d) Street No. **100 SYLVIA DR. LEMAY**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **EDWARD GOGEL**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **20**  
year **1947** hour **8:00** minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
that I last saw him alive on **Jan 20**, 19**47**  
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **JAN 3 1947**  
(Month) (Day) (Year)

Immediate cause of death **Infantile diarrhea** Duration **7 days**

Due to \_\_\_\_\_

Due to **1196**

Other conditions **Dehydration**  
(Include pregnancy within 3 months of death)  
**leukemia**

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days **17** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **ST. LOUIS Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **ALOIS GOGEL** **0**

13. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **BERNICE LARAMIE**

15. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **ALOIS GOGEL**

(b) Address **100 SYLVIA DR. LEMAY**

17. (a) **BURIAL** (b) Date thereof **JAN 22 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY CEM.**

18. (a) Signature of funeral director **Shoe Hutin & Son**  
(b) Address **2906 GRAVOIS**

19. (a) **L-23-47** (b) **Ruth J. Allen**  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy **Dehydration + leukemia**

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 **0**

23. Signature **Viet S. Hradicko** (M.D. or other) **M.D.**  
Address **508 N. Grand** Date signed **1/21/47**

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**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.....

*Leo J. Budd*

Licensed Embalmer No.....

*3989*

P. O. Address.....

*St. Louis, Mo*

**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.**