

No. 2
-1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **2552**
798
Registrar's No. _____

FILED FEB 9 1948
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 days**
(Specify whether
In this community **2 mos.**
years, months or days)

3. (a) PRINT FULL NAME **Johnny Goff**
3. (b) If veteran, name war.....
3. (c) Social Security No.

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Infant**
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive, --- years
7. Birth date of deceased **November 16 1947**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 8 hr. min.

9. Birthplace **St Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
12. Name **Anderson Goff**
13. Birthplace **Jackson, Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Mae Goff**
15. Birthplace **Jackson, Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Anderson Goff**
(b) Address **3062 Thomas**

17. (a) **Burial** (b) Date thereof **1-27-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **J. F. Preece**
(b) Address **3847 Pape**

19. (a) **FEB 27 1948** (b) **J. F. Preece**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **ood**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3062 Thomas St**
21 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **24**
year **1948** hour **4** minute **35 a.** M.

21. I hereby certify that I attended the deceased from **Jan. 9** 19**48** to **Jan. 24** 19**48**
that I last saw him alive on **Jan. 24** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Congenital Syphilis
Diarrhea
Due to.....
Due to.....
Other conditions **None**
(Include pregnancy within 3 months of death)

Duration
Undet.
PHYSICIAN
Underline the cause of which death should be charged statistically.

Major findings:
Of operations.....
Of autopsy **No**

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?..... (Specify type of place)
While at work?..... Means of injury **(1)**
23. Signature **Barrington Brouse** (M. D. or other)
Address **2601 Northwittier St** Date signed **1/26/48**

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.....

Charles King....., Registered Apprentice No. *475*
working under my personal supervision.

Signed *C. J. Nash*.....

Licensed Embalmer No. *2432*.....

P. O. Address *3847 Page*.....

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.