

FILED JAN 11 1949

State File No. 11197

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11197

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:  
3967 Labadie Ave  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 5 yrs.  
 years, months or days)

3. (a) PRINT FULL NAME Michael Frances Goggins

3. (b) If veteran, name was \_\_\_\_\_ 3. (c) Social Security No. 494-28-7243

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillian 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Sept 2nd 1907  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>3</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Paasterer

11. Industry or business Unemployed

12. Name James Goggins

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

14. Maiden name Beatrice Geraghty

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

16. (a) Informant Mrs Lillian Goggins

(b) Address 3967 Labadie Ave.

17. (a) Burial (b) Date thereof 12/29/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Natl Cent JeffBks Mo.

18. (a) Signature of funeral director Harrigan & Sheahan Und Co

(b) Address 4415 Washington Blvd.

19. (a) DEC 27 1948 (b) J B Lasater  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County over 13  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3967 Labadie Ave  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24th  
 year 1948 hour 9:00 minute P. 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 Edema of Glottis following aspiration of a piece of meat at his home 3967 Labadie Ave. on Dec 24th 1948 at about 9:00 P.M.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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

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

(b) Date of occurrence: Dec 24th 1948

(c) Where did injury occur? St. Louis Mo  
 (City or town) (County) (State)

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

(Specify type of place) \_\_\_\_\_

(M. D. or other) \_\_\_\_\_

23. Signature Patrick E. Taylor Date signed 12-27-48  
 Address 1300 Clark

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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, fact should be so stated above.