

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 28 1951

State File No. 28264
Registrar's No. 6875

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY S 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Overland #23 X	
c. LENGTH OF STAY (In this place) week		d. STREET ADDRESS (If rural, give location) 2615-Poe Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Cora b. (Middle) Adelia c. (Last) Gocke			4. DATE OF DEATH (Month) (Day) (Year) July 30, 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 31, 1871	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Nnox-City, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Elihia Hutcherson	13b. MOTHER'S MAIDEN NAME Martha Terrell	14. NAME OF HUSBAND OR WIFE Edward Gocke, Decd.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Claude Holt	ADDRESS 2615-Poe Av Overland
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis, acute, strept. type		INTERVAL BETWEEN ONSET AND DEATH 5 or 6 days
	ANTECEDENT CAUSES DUE TO (b) Carotidvascular Apoplexy		
	DUE TO (c) Thyrototoxicosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334 X	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? falling

22. I hereby certify that I attended the deceased from **7-19**, 19**51**, to **7-30**, 19**51**, that I last saw the deceased alive on _____, 19____, and that death occurred at **5 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Olford Fleishman M.D.	23b. ADDRESS 2560 A Woodson	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-2-1951	24c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery	24d. LOCATION (City, town, or county) (State) Pattonville, Mo.
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DATE RECEIVED BY LOCAL REGISTRAR AUG 1 1951	REGISTRAR'S SIGNATURE J. B. Kasater	25. FUNERAL DIRECTOR'S SIGNATURE Blumenshneider	ADDRESS Overland, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 3454

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed David E. Gilson

Licensed Embalmer No. 3454

P. O. Address Overland 14, 9

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.