

FILED JUL 22 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25809

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6385**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY <b>2119</b>	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>4635 St. Ferdinand</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <b>Link</b>		b. (Middle) <b>G.</b>	
c. (Last) <b>Goile</b>		July 1, 1952	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Dec. 30, 1945</b>
9. AGE (In years last birthday) <b>6</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>El Paso, Texas.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	13a. FATHER'S NAME <b>Cleatus Goile</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Link</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Cleatus Goile, 4635 St. Ferdinand</b> ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Lymphatic Leucemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS		Interval between onset and death <b>3 days.</b>	
Conditions contributing to the death but not related to the disease or condition causing death. <b>Lobar R Lower Pneumonia</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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 <b>2040</b>	
22. I hereby certify that I attended the deceased from <b>6-17, 1952</b> to <b>7/1, 1952</b> , that I last saw the deceased alive on <b>7/1, 1952</b> , and that death occurred at <b>11:45 a.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>George H. Brewer MD</b>	23b. ADDRESS <b>4500 Olive</b>	23c. DATE SIGNED <b>7/1/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-3-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
DATE REC'D BY LOCAL REG. <b>JUL 2 1952</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe, 4700 Washington Blvd</b> ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 3653

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.