

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **2821**  
**0766**

BIRTH NO. **REC'D FEB 2 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2427 Whittier</b>		d. STREET ADDRESS (If rural, give location) <b>2427 Whittier</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Katharine</b> b. (Middle) _____ c. (Last) <b>Gooch</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Jan. 25, 1954</b>		
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Unknown</b>	<b>9. AGE</b> (In years last birthday) <b>83</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Madison, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
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<b>13a. FATHER'S NAME</b> <b>Unknown</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mannin</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>C. T. Gooch</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>H.J. Bruce</b>		<b>ADDRESS</b> <b>2427 Whittier</b>	
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Hypertension Heart Disease</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>deep</b>
	<b>ANTECEDENT CAUSES</b>  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	<b>II. OTHER SIGNIFICANT CONDITIONS</b>  Conditions contributing to the death but not related to the disease or condition causing death.		

<b>19a. DATE OF OPERATION</b> _____	<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <b>442 X</b>
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**22. I hereby certify that I attended the deceased from 1/16, 1954, to 1/25, 1954, that I last saw the deceased alive on 1/25, 1954, and that death occurred at 5:30 p.m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <b>W.C. Payne M.D.</b> (Degree or title)	<b>23b. ADDRESS</b> <b>3426 a. Halleck</b>	<b>23c. DATE SIGNED</b> <b>1/25/54</b>
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<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>24b. DATE</b> <b>1/26/54</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> _____	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Ottumwa, Iowa</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>JAN 25 1954</b>	<b>REGISTRAR'S SIGNATURE</b> <b>J. Carl Smith M.D.</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Smith</b>	<b>ADDRESS</b> <b>4019 Washington Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
No. 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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4371

P. O. Address St. James, N

**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.