FILED DEC 20 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

44318

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2859

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Berekley — Inside Limits Yes X No ☐	c. CITY OR TOWN Berekley 4041 0 — Inside Limits Yes ☐ X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Penn Nursing Home — Length of stay in 1b 1 mo.	d. STREET ADDRESS (If outside, give location) 5923 Dowling — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First JOSEPH Middle Last GOETZ		4. DATE OF DEATH Month Day Year Dec. 1, 1956	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	8. DATE OF BIRTH April 28, 1867
9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months 8 Days 3	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (City and state or country) Parkstein, Germany	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Goetz		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT Joe Goetz Address 5923 Dowling Ave, Berekley, Missouri	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH unknown

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile dementia 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Nov 10, 1956 to Dec 1, 1956 and last saw him alive on 11/27/56

Death occurred at 2:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lewis Littmann M.D. 0	22b. ADDRESS 8231 Clayton Road St. Louis, Missouri	22c. DATE SIGNED 12/3/56
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-1-56	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F.
23d. LOCATION (City, town, or county) (State) Bismarck, Missouri		
24. FUNERAL DIRECTOR Shipman & Sons ADDRESS Bismarck, Missouri	25. DATE RECD. BY LOCAL REG. 12-4-56	26. REGISTRAR'S SIGNATURE Herbert R. Domke MD Jr.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Coroner cannot certify to a death due to natural causes. diseases in Part I must be casually related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John N. Shipman

Licensed Embalmer No. 4881

P. O. Address Bismarck, Mi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.