

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10316

STATE FILE NUMBER

FILED APR 12 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2411**

Health,
& Welfare
Public
Service

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ST. INSTITUTION 25 St. Louis City Hospital #1 Length of stay in lb 2 | | d. STREET ADDRESS (If outside, give location) 79 5420 Oriole Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle J. Last Goudy | | 4. DATE OF DEATH Month March Day 8 Year 1957 | |
| 5. SEX male c | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 19 1875 |
| 9. AGE (In years last birthday) 82 | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | IF UNDER 24 HRS. Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver | | 10b. KIND OF BUSINESS OR INDUSTRY Public Service | 11. BIRTHPLACE (City and state or country) West Virginia / |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Robert F. Goudy | |
| 14. MOTHER'S MAIDEN NAME Margaret Williams | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) Spanish American | |
| 16. SOCIAL SECURITY NO. 494 01 0037 | | 17. INFORMANT Address Lawrence Goudy 5950 Park Lane | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Poisoning Intoxication Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Emboliism from Iliac Vein Thrombosis DUE TO (c) Post Op Supra Pubic Prostatectomy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 610x | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Hour 11:55a Month 3 Day 8 Year 1957 a. m. p. m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 2-16-57 to 3-8-57 and last saw her him alive on 3-8-57 Death occurred at 11:55a m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) N.A. Kabisis, M.D. | | 22b. ADDRESS 1515 Lafayette | 22c. DATE SIGNED 3-11-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 3/11/57 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County Mo. |
| 24. FUNERAL DIRECTOR Buchholz Mortuary 5957 W. Florissant | | 25. DATE RECD. BY LOCAL REG. MAR 11 '57 | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M. J. B. |

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.....
Signature of Student Embalmer

Signed *Walter B. Buchler*

Licensed Embalmer No. 45

P. O. Address *A. J. ...*

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.