

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29484

STATE FILE NUMBER
7890

FILED SEP 4 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

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 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 INSTITUTION 25 St. Louis City Hosp.			Length of stay in lb #1	d. STREET ADDRESS 508 Pine		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES L. GOJKOVICH				4. DATE OF DEATH Month Day Year Aug. 21, 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 18, 1892		9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman		10b. KIND OF BUSINESS OR INDUSTRY Krey Packing co		11. BIRTHPLACE (City and state or country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME not known				14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 494-09-1307		17. INFORMANT Address Martha Gann 4616 Loughborough			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma of the Lung, Suspected							INTERVAL BETWEEN ONSET AND DEATH unk
Conditions, if any, which gave rise to above cause (a) DUE TO (b) stating the underlying cause (c) DUE TO (c) Pneumonia, duration unk							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Paralysis, left due to C.V.A. duration unk							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) 162x				
20c. TIME OF INJURY Hour Month, Day, Year 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 6/20/57 to 8/21/57 and last saw her/him alive on 8/21/57 Death occurred at 10:10 P.M. from the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Jean A. Chapman, M.D.				22b. ADDRESS 1515 Lafayette		22c. DATE SIGNED 8/22/57.	
23a. BURIAL CREMATION, REMOVAL (Specify) removal		23b. DATE 8/24/1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS J L Ziegenhein & Sons 7027 Gravois				25. DATE RECD. BY LOCAL REG. AUG 23 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-56
no symptoms were observed. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Coroner cannot certify to a death due to natural causes.

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 embalmed
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *E. P. Kidwell*.....

Licensed Embalmer No. *387*

P. O. Address *7027 1/2*

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.