

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29488

STATE FILE NUMBER

FILED AUG 26 1957

318

1003

7395

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Mo.</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		c. CITY OR TOWN <i>ST. LOUIS, MO.</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSP.</i>		d. STREET ADDRESS <i>2900 HENRIETTA</i>	
3. NAME OF DECEASED (Type or print) First <i>SUSIE</i> Middle <i>ANN</i> Last <i>GOLDSBERRY</i>		4. DATE OF DEATH <i>July 29, 1957</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/29/57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>no</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (City and state or country) <i>ST. LOUIS, MO.</i>
13. FATHER'S NAME <i>NILE GOLDSBERRY</i>		14. MOTHER'S MAIDEN NAME <i>ALICE JANE HANSON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT Address <i>ST. LOUIS CITY HOSP. #1.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency</i> DUE TO (b) <i>Immaturity</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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 _____ 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 <i>7/29/57</i> to <i>7/29/57</i> and last saw her alive on <i>7/29/57</i> Death occurred at <i>4:30 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Queenie L. Carr M.D.</i>		22b. ADDRESS <i>1515 LAFAYETTE AVE.</i>	22c. DATE SIGNED <i>8/6/57.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>8-31-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo</i>
24. FUNERAL DIRECTOR ADDRESS <i>Rawland - aka 404 Manchester</i>	25. DATE RECD. BY LOCAL REG. <i>AUG 8 '57</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i>	

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Caroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address

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.