

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

42012  
STATE FILE NUMBER

FILED NOV 19 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No. 10738

V. S. 300  
Rev. 1-57

8

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 All diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATE NUMBER 12-1957-111

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) <b>25 HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.</b>		Length of stay in 1b <b>#1</b>		9. STREET ADDRESS (If outside, give location) <b>1415 Cockrell</b>	
3. NAME OF DECEASED (Type or print) <b>ELLEN</b>		First Middle Last <b>GOGGINS Goggin</b>		4. DATE OF DEATH Month Day Year <b>NOV. 10, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-22-1888</b>	9. AGE (In years last birthday) <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	
13a. FATHER'S NAME <b>John Goggin</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Klump</b>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Robert Ruhland 6215a Easton</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Excitatory Ca Rt Heart, mitrated to Lung &amp; Pericardium</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a)					
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.) <b>170x</b>		
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 <b>9/6/57</b> to <b>11/10/57</b> and last saw her alive on <b>11/10/57</b> Death occurred at <b>2:00 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Name or title) <b>J. Carl Smith, M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>11/11/57</b>		23a. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23b. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
23c. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23d. DATE <b>11-13-1957</b>		23e. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
24. FUNERAL DIRECTOR <b>Jos. W. Clark</b>		ADDRESS <b>F.H. 1125 Hodiamont</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 12 '57</b>	
26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>M. J. B.</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 *Alfred J. Boeder* .....

Licensed Embalmer No. *2463*  
P. O. Address. *1123 Hudson*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.