

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002988

STATE FILE NUMBER

370

FILED JAN 28 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300

1-57

164

1

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3731 LOUISIANA AVE</u>			Length of stay in 1b		d. STREET (If outside, give location) ADDRESS <u>3731 LOUISIANA</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>CECILE MARIE GOUDEAU</u>				4. DATE OF DEATH Month Day Year <u>JAN 10 1959</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 31 1873</u>		9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>LOUISIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>		
13a. FATHER'S NAME <u>CITON LOUIS BONNETTE</u>			13b. MOTHER'S MAIDEN NAME <u>FLAVIA RICARDE</u>			14. NAME OF HUSBAND OR WIFE <u>MARTIN PIERRE GOUDEAU</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>AGNES ADAM 3731 LOUISIANA</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Smile pneumonia</u>		DUE TO (c) <u>420.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT <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 <u>Nov 24-1955</u> and last saw her alive on <u>1-10-59</u> Death occurred at <u>1-10-59</u> <u>6:05</u> <u>A</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>M. W. Hanshosoc M.D.</u>					22b. ADDRESS <u>3124 Arsenal St.</u>		22c. DATE SIGNED <u>1-12-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JAN 13 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL</u>		23d. LOCATION (City, town, or country) <u>ST. LOUIS</u>		(State) <u>MO</u>	
24. FUNERAL DIRECTOR <u>Thomas Katis 2906 Gravois</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JAN 12 '59</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		

115 2-27-2003  
Heure 5:10 P.M.  
DA 2-22-44

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 Eleanore

Licensed Embalmer No. 3403  
P. O. Address Jennings

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.