Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-022922
STATE FILE NUMBER

FILED JUL 1 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 5773

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN ST.LOUIS, MO — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION ST.LOUIS CIT Y HOSP. #1. — Length of stay in Hospital	d. STREET ADDRESS (If outside, give location) 2638 Wyoming — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
JOHN		GOETTER	JUNE 16, 1959

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Separated	March 3 1875	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
RetiRed		Mo	U S A

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Unknown	Unknown	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	321-01-5688	Joseph Goetter	2638 Wyoming

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gangrene of Right Lower Extremity

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis Obliterans

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 450.1

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 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 6/11/59, to 6/16/59 and last saw her/him alive on 6/16/59. Death occurred at 9:23 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Samuel R Joseph M.D.	1515 LAFAYETTE AVE	6/17/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	June 20 1959	Sunset Burial Park	St Louis Co. Mo

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Thomas Kutis	2906 Gravois	JUN 17 '59	Earl Smith, M.D. MYB

(Licensed Embalmer's Statement on Reverse Side)

All 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 embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. .....

P. O. Address 2906 Daw

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.