

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036834

FILED VS. SEP 19 1960

Registration District No.

317

Primary Registration District No.

541

Registrar's No.

2728

STATE FILE NUMBER

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>  |  | Length of stay in 1b<br><b>1 Wk.</b>  | c. CITY OR TOWN <b>Richmond Hgts.</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hosp.</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <b>7532 Warner</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Ignatius</b> First <b>Goldmann</b> Middle <b>G</b> Last   |  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>12</b> Year <b>60</b>   |  |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>           | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr. 26, 1897</b>  | 9. AGE (last birthday)<br><b>63</b>  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>17</b> Hours <b></b> Min. <b></b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Druggist</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>                          |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |   | 13a. FATHER'S NAME<br><b>Ignatius Goldmann</b>  |  |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>Mary Hoppe</b>  |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>-----</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes World War I</b>  |  | 16. SOCIAL SECURITY NO.<br><b>492-01-2165</b>   |   | 17. INFORMANT<br><b>Arthur Goldmann 7532 Warner Ave.</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>   |  |   |   |  | <b>1 wk</b>  |
| DUE TO (b) <b>Bullos Emphysema with ruptured bleb</b>   |  |   |   |  | <b>15 yrs</b>  |
| DUE TO (c) <b>Bronchial Asthma</b>  |  |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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.) |  |
| 20c. TIME OF INJURY<br>Hour <b></b> Month, Day, Year <b></b>  |  |   |   |  |  |
| 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>9-4-60</b> to <b>9-4-60</b> and last saw her/him alive on <b>9-4-60</b><br>Death occurred at <b>3:15 P</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Paul W. Schaper MD</b> (Degree or title)   |  |   | 22b. ADDRESS<br><b>6015a Brentwood Clayton Mo.</b>  |  | 22c. DATE SIGNED<br><b>9-12-60</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>Sept. 15, 1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b>   |
| 24. FUNERAL DIRECTOR<br><b>A. H. Bocklage F.H. 6536 Clayton Rd.</b> ADDRESS   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>9-14-60</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>J. M. Murphy M.D.</b>  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4590

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.