

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 26 1960

318

Primary Registration District No. 1003

Registrar's No. 10074

60-029762

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b Life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSITUATION Missouri Baptist Hosp.		d. STREET ADDRESS (If outside, give location) 4049 Botanical	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last WALTER A. GODBEY			4. DATE OF DEATH Month Day Year 10 15 60		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/21/70	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William Godbey	13b. MOTHER'S MAIDEN NAME Carrie Smith	14. NAME OF HUSBAND OR WIFE Margaret (Dec'd)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address Lurline Hiliker, 4049 Botanical
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 day 7 years
IMMEDIATE CAUSE (a)	<i>Coronary occlusion</i>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	<i>Arteriosclerotic heart disease</i>	
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from <i>Mar 12, 1953</i> to <i>Oct 15, 1960</i> and last saw him alive on <i>Oct 15, 1960</i> . Death occurred at <i>P. 30</i> <i>P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>Monty J. Covarsell M.D.</i>	22b. ADDRESS <i>6356 Clayton Rd. St Louis 17, Mo</i>	22c. DATE SIGNED <i>Oct 16, 1960</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/18/60	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette	25. DATE RECD. BY LOCAL REG. OCT 18 1960	26. REGISTRAR'S SIGNATURE <i>Coal Smith M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 3 1961

MAR 2 1961

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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