

AMENDED FILED MAR 27 1961 Primary Registration District 1003 Registrar's No. 2339 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH  
 a. COUNTY  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Missouri** Length of stay in lb **3 Hours**  
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Mary's Infirmary** Inside Limits Yes  No   
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE **Illinois** COUNTY **St. Clair**  
 c. CITY OR TOWN **East St. Louis** Inside Limits Yes  No   
 d. STREET ADDRESS (If outside, give location) **400 North 24th St.** Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First **WILLIAM** Middle Last **GOSS** 4. DATE OF DEATH Month **March** Day **8** Year **1961**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH **5/28/02** 9. AGE (last birthday) **58** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

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

13a. FATHER'S NAME **CHARLIE GOSS** 13b. MOTHER'S MAIDEN NAME **EMILY (UNKNOWN)** 14. NAME OF HUSBAND OR WIFE **NONE**

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. **Unknown** 17. INFORMANT **Mrs. R.L. Dawkins, 400 No. 24th St.** Address **E. St. Louis, Ill.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **CORONARY OCCLUSION** INTERVAL BETWEEN ONSET AND DEATH **12 Hrs**  
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **4201**  
 DUE TO (c)

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.  
 Yes  No  Unknown

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 **3/1/61** to **3/8/61** and last saw her alive on **3/8/61**  
 Death occurred at **3:15 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Frank S. Woodson, M.D.** 22b. ADDRESS **1516 E. BROADWAY** 22c. DATE SIGNED **3/9/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **3/12/61** 23c. NAME OF CEMETERY OR CREMATORY **Local Cemetery** 23d. LOCATION (City, town, or county) (State) **Louisville, Mississippi**

24. FUNERAL DIRECTOR **Marion's Office** ADDRESS **2114 Missouri E. St. Louis, Ill.** 25. DATE RECD. BY LOCAL REG. **MAR 10 1961** 26. REGISTRAR'S SIGNATURE **Paul Smith M.D.**

**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 Frank Proff

Licensed Embalmer No. 4356  
P. O. Address Madison Mo

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.