

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040250

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 818 Primary Registration District No. 1093 Registrar's No. 10066

FILED OCT 29 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>10 Days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>		c. CITY OR TOWN <u>Granite City</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>Missouri Baptist</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2612 State Street</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred Josephine Goldsberry</u>						4. DATE OF DEATH Month Day Year <u>10 21 1962</u>		9. AGE (last birthday) <u>51</u>		IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2-1-1911</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Union Starch</u>		11. BIRTHPLACE (City and state or country) <u>Urbana, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>Benjamin F. Kemper</u>				13b. MOTHER'S MAIDEN NAME <u>Jessie Ruth Hayes</u>				14. NAME OF HUSBAND OR WIFE <u>James Reuch</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>6041 Rochelle Ave. Parma Hgts. Cleveland, Ohio</u>		17. INFORMANT <u>James Reuch</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post-Operative Shock</u> DUE TO (b) <u>Hemorrhage</u> DUE TO (c) <u>Diffuse Carcinomatosis (Breast)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>170x</u>			
19. WAS AUTOPSY PERFORMED? 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.) <u>170x</u>							
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					
21. I attended the deceased from <u>10-12-62</u> to <u>10-21-62</u> and last saw her alive on <u>10-21-62</u> . Death occurred at <u>7:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>W. B. Serwick MD</u>						22b. ADDRESS <u>453 N. Taylor</u>			22c. DATE SIGNED <u>10/22/62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-22-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Local Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>West Lafayette Ind.</u>					
24. FUNERAL DIRECTOR <u>Pieper Funeral Home</u>				25. DATE RECD. BY LOCAL REG. <u>10-22-1962</u>		26. REGISTRAR'S SIGNATURE <u>Road Smith. M.D.</u>					

**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 NOT EMBALMED, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Henry J. Bizer  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address Granite City, Ill.

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.