

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048374

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12076** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED DEC 21 1962</b>	
1. PLACE OF DEATH a. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>	
Length of stay in 1b <b>6 1/2 yrs</b>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <b>3164 N. 11th St</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALEX</b> Middle <b>GOINS</b> Last	
4. DATE OF DEATH Month <b>12</b> Day <b>16</b> Year <b>62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-72</b>
9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>
11. BIRTHPLACE (City and state or country) <b>Ky.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>LAVENIA (Unknown)</b>
14. NAME OF HUSBAND OR WIFE <b>MARY STONEY GOINES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT (daughter) <b>Mrs. Norman Sailors</b>	Address <b>6562 Curtis Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>420.0</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b> <b>20 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchopneumonia - Decubiti</b>	
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	
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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>12-4-56</b> to <b>12-16-62</b> and last saw her alive on <b>12-15-62</b> Death occurred at <b>3:25 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>John J. Keenan M.D.</b> (Degree or title)	22b. ADDRESS <b>5800 Arsenal Ave</b>
22c. DATE SIGNED <b>12-17-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-19-1962</b>
23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>	
24. FUNERAL DIRECTOR <b>McMikle Funeral Home</b> ADDRESS <b>East Prairie, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 17 1962</b>
26. REGISTRAR'S SIGNATURE <b>Lois Smith, M.D.</b>	

USE BLACK INK OR TYPEWRITER RIBBON

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**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 James L. Crosson

Licensed Embalmer No. 5168

P. O. Address Waltham, MA

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.