

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5218-63-021620  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUDY

AMENDED

1. <b>FILED MAY 27 1963</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b _____		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>927 Park Avenue</b>	
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)			4. DATE OF DEATH
First <b>Oletha</b> Middle <b>M.</b> Last <b>Goff</b>			Month <b>May</b> Day <b>13</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/1925</b>
9. AGE (last birthday) <b>37</b>		IF UNDER 1 YEAR	IF UNDER 24 HR
		Months _____ Days _____	Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Patrick Samsencie</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Schutte</b>	14. NAME OF HUSBAND OR WIFE <b>Lilburn</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <b>No</b>		17. INFORMANT Address <b>Lilburn Goff 927 Park, St. Louis, Mo.</b>	
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	
IMMEDIATE CAUSE (a) <b>Heart Failure</b>			
DUE TO (b) <b>Embolic of Lungs</b>			
DUE TO (c) <b>5-81.0</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. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 <b>Mar 1962</b> to <b>May 13, 1963</b> and last saw her <b>live on May 13, 1963</b> Death occurred at <b>11:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Preston C. Hall M.D.</b>		22b. ADDRESS <b>3902a Lafayette</b>	22c. DATE SIGNED <b>5/15/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>May 17, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county). <b>Jefferson Barracks, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>C. Hoffmeister Mortuaries 2814 So. Broadway St. - Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 15 1963</b>	26. REGISTRAR'S SIGNATURE <b>Hoan Smith, M.D.</b>

VS 300  
Rev. 4/59

1  
2 **22**  
3  
4 **1**  
5 **1**  
6  
7 **0**  
8 **2**  
9  
10  
11  
12 **53-0**  
13

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**53**

2518-02-051850

8001

816



**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 John S. Penney  
Licensed Embalmer No. 4194

P. O. Address St. Louis 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.

Dr. Preston Hall  
3902 Lafayette

FR 1-8074