

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

DEC'D AUG 12 1938

23247  
Do not use this space.  
5941

791  
1003

**1. PLACE OF DEATH**

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) City St. Louis (d) Street No. St. Lukes Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Joseph W. Gohn

(a) Residence, No. 4338 Washington Ave. St. 19  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katherine Gohn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 1, 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
65 4 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Chauffeur  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

FATHER 13. NAME John Gohn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

MOTHER 15. MAIDEN NAME Mary Major

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT L. A. Gohn  
 (ADDRESS) 4338 Washington Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE July 4, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Charles E. Thomas Home 4911 Washington Bl.

20. FILED JUL 2 1938 J. D. Beedick  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 1 1938

22. I HEREBY CERTIFY that I attended deceased from Mr. 10 to July 1 1938

I last saw him alive on June 30 1938 Death is said to have occurred on the date stated above, at 7:30 A.M.

The principal cause of death and related causes of importance were as follows:

Carcinoma Cervicis, Primary 1937  
H&F

Other contributory causes of importance:  
Carcinoma - liver - metastatic glands and intestine - metastatic 1937  
Cholera and dysentery

Name of operation Cholera and dysentery Date of Nov 15 1938  
 What test confirmed diagnosis? Cholera Was there an autopsy? yes

23. If death was due to external causes (violence) fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Oscar P. Smith (SEV. N.)  
 (Address) 2700 Washington St. Home Mo.

**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, Myself.  
or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Elton H. Remick

Licensed Embalmer No. 3154

P. O. Address 3948<sup>th</sup> Green Ave.  
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 this body is not embalmed, above space should be left blank.