

FILED JUN 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15527

State File No.

39
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6

BIRTH NO. 134416-49 REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 2000 Registrar's No. 494-C

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Dade Co.	
b. CITY OR TOWN Springfield	c. LENGTH OF STAY (in this place) 2 days	c. CITY OR TOWN Everton	21
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If rural, give location) 1	0

3. NAME OF DECEASED (Type or Print) a. (First) Raymond b. (Middle) K. c. (Last) Goodman			4. DATE OF DEATH (Month) (Day) (Year) June 2 1949		
5. SEX m.	6. COLOR OR RACE w.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH March 20 - 1949	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Mo.	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Leonard Goodman	13b. MOTHER'S MAIDEN NAME Anna Lee Jones	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	17. INFORMANT'S SIGNATURE OR NAME Leonard Goodman (father)	ADDRESS Everton
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Intestinal Indigestion		INTERVAL BETWEEN ONSET AND DEATH 1 mo
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gastric hemorrhage		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **J-31** **1949** to **6-2**, **1949**, that I last saw the deceased alive on **6-2**, **1949**, and that death occurred at **4:12 m.**, from the causes and on the date stated above.

23a. SIGNATURE Urban Busch (Degree or title)	23b. ADDRESS 150 Springfield Ave	23c. DATE SIGNED 6-8-49
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24a. BURIAL (Specify) Winking Creek	24b. DATE 6-3-49	24c. NAME OF CEMETERY OR CREMATORY Winking Creek	24d. LOCATION (City, town, or county) (State) Dade Co. Mo.
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DATE REC'D BY LOCAL REG. 6/9/49	REGISTRAR'S SIGNATURE W.F. Landley	25. FUNERAL DIRECTOR'S SIGNATURE Martha Seiman	ADDRESS 10th Street, Mo.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.

Signed _____

E. R. Simon

Signed _____

Student Embalmer

Licensed Embalmer No. _____

3297

P. O. Address _____

Miller Mo.

Body was Not Embalmed.

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, fact should be so stated above.