

FILED JUL 18 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Semaca  
State File No. 25837

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 355 PRIMARY REG. DIST. NO. 6204 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Texas</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Summersville</u>		c. LENGTH OF STAY (in this place) <u>DATE 37 years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Summersville</u>		d. STREET ADDRESS (If rural, give location)
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Edward</u> c. (Last) <u>Goodin</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6-5-49</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13-1879</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Talamco, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Thomas Goodin</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Davenport</u>		14. NAME OF HUSBAND OR WIFE <u>Rachel V Goodin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Chas E Goodin Summersville, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Conjectured Head Injury</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH  <u>42 1/2</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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)	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 <u>5-31</u> , 19 <u>49</u> , to <u>6-2</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5-31</u> , 19 <u>49</u> , and that death occurred at <u>8:30</u> a.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Dr. J. W. V. Mountain View, Mo.</u>			23b. ADDRESS <u>Mountain View, Mo.</u>		23c. DATE SIGNED <u>8-6-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-8-49</u>	24b. DATE <u>6-8-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Side</u>	24d. LOCATION (City, town, or county) (State) <u>Arrol, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>6-30-49</u>	REGISTRAR'S SIGNATURE <u>Thos C. E. Murphy</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Duncan Funeral Home Mtn View, Mo</u>		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED

7-9-49

District Health Officer No. 5,

District No. Number 749486

Date Filed 7-14-49

**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 \_\_\_\_\_

*Joel S. Duncan*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4325

P. O. Address W. W. View Co.

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.