

No. 300  
10.48

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32648**

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3671 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>	
c. LENGTH OF STAY (in this place) <u>31 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>J</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>Florence</u>	b. (Middle) <u>Melvina</u>	c. (Last) <u>Goodman</u>	<u>Oct. 2--1949</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug. 8th 1868</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Saline County, Mo.</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	

13a. FATHER'S NAME <u>Thos. Shepard</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca M. Varson</u>	14. NAME OF HUSBAND OR WIFE <u>widow</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lottie Karmeyer,</u> ADDRESS <u>Slater, Mo.</u>

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		<u>7 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Chronic Nephritis</u>		<u>years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Arteriosclerosis</u>		<u>331X</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 July, 1949, to Oct 2, 1949, that I last saw the deceased alive on Oct 2, 1949, and that death occurred at 1 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>C. A. McBurney M.D.</u> (Degree or title)	23b. ADDRESS <u>Slater, Mo.</u>	23c. DATE SIGNED <u>10/5/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/5/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Slater City</u>	24d. LOCATION (City, town, or county) (State) <u>Slater, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10-5-49</u>	REGISTRAR'S SIGNATURE <u>Ms. Earl C. Metz</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Brothers</u> ADDRESS <u>Slater, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED OCT 10

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 10-15-49

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.

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

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Statesville, N.C.

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.