

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34777

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09
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. 298		PRIMARY REG. DIST. NO. 4448		Registrar's No. 23	
1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lawson</u>		c. LENGTH OF STAY (In this place) <u>7 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lawson</u>		d. STREET ADDRESS (If rural, give location) <u>8</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>				d. STREET ADDRESS (If rural, give location) <u>8</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LILY</u>			b. (Middle) <u>MAE</u>			c. (Last) <u>GOLDSBURY</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 25, 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>July 12, 1882</u>		9. AGE (In years last birthday) <u>67</u>		if UNDER 1 YEAR Months <u>3</u> Days <u>13</u>		if UNDER 1 MRS. Hour <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>			11. BIRTHPLACE (State or foreign country) <u>Ray Co. Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13a. FATHER'S NAME <u>Johnson Gullett</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>	
14. NAME OF HUSBAND OR WIFE <u>John Goldsbury</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT'S SIGNATURE OR NAME <u>John Goldsbury</u>				17. ADDRESS <u>Lawson 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, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage Left Hemisphere</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential Hypertension</u>				<u>10 years</u>	
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <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 (Specify) <u>SUICIDE</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Lawson</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Ray Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>Oct. 24, 1949</u> , to <u>Oct. 25, 1949</u> , that I last saw the deceased alive on <u>Oct. 25, 1949</u> , and that death occurred at <u>12:45 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Delius E. Duerker, M.D.</u>				23b. ADDRESS <u>Lawson Mo</u>		23c. DATE SIGNED <u>Oct. 25, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 27, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 26, 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs. Raymond Hoover</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jarman - Prichard</u>			
				ADDRESS <u>Lawson Mo</u>			

RECEIVED NOV 1

District Health Officer No. 8,

District File Number

Date Filed 11-4-49

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

Lindee K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.