

FILED MAY 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 14182

BIRTH NO. _____		REG. DIST. NO. <u>294</u>		PRIMARY REG. DIST. NO. <u>3056</u>		Registrar's No. <u>104</u>			
1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Moberly</u>		c. LENGTH OF STAY (In this place) <u>5 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Moberly</u>		OR TOWN <u>0803</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodland Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>724 First Ave. D</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLARD</u> b. (Middle) <u>FRANKLIE</u> c. (Last) <u>GODDARD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April-14-1950</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan-22-1883</u>			
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR <u>2</u> Months <u>23</u> Days		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Parts</u>		11. BIRTHPLACE (State or foreign country) <u>Dunkville Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Goddard</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Ferrill</u>		14. NAME OF HUSBAND OR WIFE <u>Florence Goddard</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Florence Goddard</u>		ADDRESS <u>Moberly 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Severe Left Sided Hemiplegia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 da</u>		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u>					<u>5 da</u>		
		DUE TO (c) <u>Cerebral Arteriosclerosis</u>					?		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arterial Hypertension</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) <u>331X</u>					
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 <u>Apr 9</u> , 19 <u>50</u> , to <u>Apr 14</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Apr 14</u> , 19 <u>50</u> , and that death occurred at <u>11:45</u> a.m., from the causes and on the date stated above.									
23a. SIGNATURE <u>W. L. [Signature]</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Moberly, Mo.</u>		23c. DATE SIGNED <u>Apr 14, 1950</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>April-16-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Moberly Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Apr 16-50</u>		REGISTRAR'S SIGNATURE <u>Earl [Signature]</u>		FUNERAL DIRECTOR'S SIGNATURE <u>John [Signature]</u>		ADDRESS <u>Funeral Home Moberly Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

MAY 10 1951

DEC 10 1951

MAY

RECEIVED

APR 27

District Health Officer

District File Number 4-58

Date Filed

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

*R. M. Carter*

Licensed Embalmer No.

4117

P. O. Address

*Ma. Berly M*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.