

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35077

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9136**

1. PLACE OF DEATH a. COUNTY <b>---</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Montgomery</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis, Missouri</b> )		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Hillsboro</b>	
c. LENGTH OF STAY (In this place) <b>12 days</b>		d. STREET ADDRESS (If rural, give location) <b>470 E. Tremont</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Marie</b> b. (Middle) <b>Lucille</b> c. (Last) <b>Goad</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>October 15, 1951</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 19, 1922</b>	9. AGE (In years last birthday) <b>28</b>	IF UNDER 1 YEAR Months IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Litchfield, Ill.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					

13a. FATHER'S NAME <b>Thomas Tibbs</b>	13b. MOTHER'S MAIDEN NAME <b>Allie Blankenship</b>	14. NAME OF HUSBAND OR WIFE <b>Robert Goad</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Thomas Tibbs, Litchfield, Ill.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Periarteritis Nodosa</b>		ANTECEDENT CAUSES		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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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? <b>H56X</b>
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22. I hereby certify that I attended the deceased from **October 319 51, to Oct. 15, 19 51**, that I last saw the deceased alive on **Oct. 15, 19 51**, and that death occurred at **6:30 P m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>F. R. Bradley, M.D.</b> (Degree or title)	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>10/15/51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10-16-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove,</b>	24d. LOCATION (City, town, or county) (State) <b>Hillsboro, Ill.</b>
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DATE REC'D BY LOCAL REG. <b>Oct 16 1951</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....

Signed.....  
*John A. Demme*

Licensed Embalmer No..... *4194*

P. O. Address.....

**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.