S. No. 300
v. 10.48

FILED JUL 17 1952

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24973

BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 3037 Registrar's No. 91

1. PLACE OF DEATH
a. COUNTY Lawrence
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt Vernon
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Lawrence
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt Vernon
d. STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Alexander c. (Last) Gooding

4. DATE OF DEATH (Month) July (Day) 13 (Year) 1952

5. SEX Mo
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Aug 30 1867
9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months 10 Days 13 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Mt Vernon, Mo R F D O
12. CITIZEN OF WHAT COUNTRY? Usa

13a. FATHER'S NAME John Gooding
13b. MOTHER'S MAIDEN NAME Lenora Hammers (not known)
14. NAME OF HUSBAND OR WIFE Katie Bell Gooding

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. X
17. INFORMANT'S SIGNATURE OR NAME Mrs Maude Towers, Mt Vernon ADDRESS

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) Uremic poisoning — INTERVAL BETWEEN ONSET AND DEATH 30 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prostatitis — 5 years
DUE TO (c) Prostate removed — Apr 1949

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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* July 14, 1952 *that I last saw the deceased alive on* July 13, 1952, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE P A Holmes (Degree or title) M.D.O
23b. ADDRESS Mt Vernon Mo
23c. DATE SIGNED 7-14-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried
24b. DATE July 15-52
24c. NAME OF CEMETERY OR CREMATORY Brick Church
24d. LOCATION (City, town, or county) 6 mi. North Mt Vernon (State) Mo

DATE REC'D BY LOCAL REG. 7-15-52
REGISTRAR'S SIGNATURE Cecil Hendricks 4/1-D
25. FUNERAL DIRECTOR'S SIGNATURE Geo B Orr ADDRESS Mt Vernon Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 George B. Orr

Licensed Embalmer No. 946

P. O. Address Mt Vernon MO

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.