

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15230**

No. 300  
10.48

FILED JUN 1 1954

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

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>64</u>  |  | PRIMARY REG. DIST. NO. <u>4110</u>  |  | Registrar's No. <u>33</u>  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Chariton</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u>   |  |  |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Salisbury</u>  |  | c. LENGTH OF STAY (in this place) <u>6yrs</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Salisbury</u>   |  | d. STREET ADDRESS (If rural, give location) <u>402 So. Weber</u>                 |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>402 South Weber</u>   |  |   |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 22-1954</u>  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Mary</u>  |  | b. (Middle) <u>Kizzie</u>   |  | c. (Last) <u>Gooch</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>April 6-1854</u>   |  |  |  |
| 9. AGE (in years) last birthday <u>100</u>   |  | 10. 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>None</u>   |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>Near Roanoke Missouri</u>  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  | 13a. FATHER'S NAME <u>John Henry Wayland</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>Martha Dysart</u>  |  | 14. NAME OF HUSBAND OR WIFE <u>David Gooch</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. T.D. Scoggins</u> ADDRESS <u>Salisbury Mo.</u>  |  |  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                    |  |   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral apoplexy</u><br>ANTECEDENT CAUSES <u>arteriosclerosis</u><br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  | INTERVAL/BETWEEN ONSET AND DEATH<br><u>3 da</u><br><u>15 yoo</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) 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>5-21-54</u> , 19 <u>54</u> , to <u>5-22-1954</u> that I last saw the deceased alive on <u>5-22-1954</u> , and that death occurred at <u>9:00 A. m.</u> , from the causes and on the date stated above. |  |   |  |   |  |  |  |  |  |
| 23a. SIGNATURE (Degree or title) <u>[Signature]</u>  |  |   |  | 23b. ADDRESS <u>Salisbury Mo.</u>   |  | 23c. DATE SIGNED <u>5-24-54</u>  |  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>  |  | 24b. DATE <u>5-24-54</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Roanoke Cemetery</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>Roanoke Mo.</u>                 |  |  |  |
| DATE REC'D BY LOCAL REG. <u>5-24-54</u>  |  | REGISTRAR'S SIGNATURE <u>[Signature]</u> 55-  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas B Winhelmyer</u> ADDRESS <u>Salisbury Mo.</u>  |  |  |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

**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 Chas B Winkelmeier

Licensed Embalmer No. 3842

P. O. Address Salisbury 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.