FILED JUN 4 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15613

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 586

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 917 No. 12th St. — Length of stay in lb 13 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 917 No. 12th St. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last GOFORTH

4. DATE OF DEATH Month May Day 25 Year 1956

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Nov. 29, 1873

9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (City and state or country) Nodaway Missouri

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME John Calvin Goforth

14. MOTHER'S MAIDEN NAME Mary Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Not known

17. INFORMANT Mrs. Ora Goforth — Address St. Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 4 yrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1952, to 5-25-56 and last saw her/him alive on 5-22-56
Death occurred at 5-25-56 5:15 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Clement Carlyman M.D.

22b. ADDRESS St. Joseph Mo

22c. DATE SIGNED 5-25-56

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 5-28-56

23c. NAME OF CEMETERY OR CREMATORY Barnard Cemetery

23d. LOCATION (City, town, or county) Barnard (State) Missouri

24. FUNERAL DIRECTOR Stamey Funeral Home — ADDRESS St. Joseph, Mo.

25. DATE RECD. BY LOCAL REG. May 31, 1956

26. REGISTRAR'S SIGNATURE Esther M. Allison

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Charles E. Bennett

Licensed Embalmer No. 4

P. O. Address St. Jos

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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