

X Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

28433

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7544**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Perry</b>		
b. CITY (If outside corporate limits, give-TOWNSHIP only) OR TOWN <b>St. Louis,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Tamaro</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>		Length of stay in lb <b>12 Hrs.</b>	d. STREET ADDRESS (If outside, give location) <b>--</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>Goforth</b> Last <b>Goforth</b>			4. DATE OF DEATH Month <b>8</b> Day <b>13</b> Year <b>56</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-1891</b>	9. AGE (In years last birthday) <b>64</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>	11. BIRTHPLACE (City and state or country) <b>Galatin, Illinois,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Goforth</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Woodworth</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W. W. # 1</b>		16. SOCIAL SECURITY NO. <b>330-16-2377</b>	17. INFORMANT Address <b>Imogene Goforth, Tamaro, Ill.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hematoma,</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>suffered when car operated by Carl Moore, in which deceased was a passenger, was struck by tractor</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tractor operated by Carl James Maden, at intersection of Chippewa and Nevada Aves.,</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>about 6:05 pm on August 12th, 1956.</b>				
20c. TIME OF INJURY Hour <b>6:05</b> Month, Day, Year <b>8 12 56</b>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>				20e. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b> COUNTY <b>26</b> STATE
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>745A m</b> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <b>Patrick J. Taylor</b> (Degree or title)		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>8.14.56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-13-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tamaro Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Tamaro, Illinois,</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington,</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 14 1956</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S.P.

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.....  
Signature of Student Embalmer

Signed *G. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.