

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31270

STATE FILE NUMBER

DECEASED SEP 18 1956

Registration District No. 383

Primary Registration District No. 5655

Registrar's No. 42

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gallaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Fulton</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u> Length of stay in 1b <u>451 days</u>		d. STREET ADDRESS (If outside, give location) <u>407 Oak</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u></u> Last <u>Gilman</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 11, 1877</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Gallaway County, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Goodrich</u>	
14. MOTHER'S MAIDEN NAME <u>Fanny McCall</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>500-34-3424</u>		17. INFORMANT <u>San. records, Mo. State San. Mt. Vernon, Mo.</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Pulmonary tuberculosis: Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>abt. 6 hours</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input 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.) <u></u>		20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	
20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>June 16, 1955</u> to <u>Sept. 9, 1956</u> and last saw her alive on <u>9-9-56</u> . Death occurred at <u>12:05 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Cecil Handricks M.D.</u>		22b. ADDRESS <u>Mt. Vernon, Missouri</u>	
22c. DATE SIGNED <u>9-10-56</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>Sept-9-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u></u>	
23d. LOCATION (City, town, or county) <u>Fulton</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Max L. Fossett</u> ADDRESS <u>Mt. Vernon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-10-56</u>	
26. REGISTRAR'S SIGNATURE <u>Cecil Handricks</u>			

(Licensed Embalmer's Statement on Reverse Side)

11-0

SEP 30 1958

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 *May L. Fissett*.....

Licensed Embalmer No. *425*

P. O. Address *Mt Vernon*

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.