

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8101

STATE FILE NUMBER

FILED MAR 26 1957

Registration District No. 93 Primary Registration District No. 5335 Registrar's No. 57-20

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>Dade</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marion Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Sheldon</u>		1080 0 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>H/W 160 2 1/2 Mi. W of Golden</u>		Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>City</u>	
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>A.</u> Last <u>GOOCH</u>			4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1895</u>	9. AGE (In years last birthday) <u>61</u> IF UNDER 1 YEAR: Months <u>0</u> Days <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>Car Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ford Agency</u>		11. BIRTHPLACE (City and state or country) <u>Orrick Mo.</u>	
13. FATHER'S NAME <u>James Gooch</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give way or dates of service) <u>Yes W I</u>		
16. SOCIAL SECURITY NO. <u>496-10-8433</u>		17. INFORMANT <u>Mrs. Mary Francis Gooch</u> Address <u>Sheldon Mo</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>Skull fracture and multiply fractures and internal injurys</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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>Car and Train Accident</u>		
20c. TIME OF INJURY Hour <u>11:30</u> Month <u>March</u> Day <u>14</u> Year <u>57</u> <u>a.m.</u> <u>p.m.</u>					
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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>H/W 160 R.R. Crossing</u>		20f. CITY, TOWN, OR LOCATION <u>Marion Twp</u> COUNTY <u>Dade</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>After death</u> to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. R. Allison, Coroner</u> <u>3</u>			22b. ADDRESS <u>Greenfield Mo.</u>		22c. DATE SIGNED <u>3/14/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 18 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>So. Point Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Orrick Mo</u>
24. FUNERAL DIRECTOR <u>Beeny Funeral Home</u>		ADDRESS <u>Sheldon Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3/18/57</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>

MAR 29 1953

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *L. Gerald Beeny*

Licensed Embalmer No. *42*

P. O. Address *Sheldon*

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.