

FILED SEP 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34540

STATE FILE NUMBER

 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 163

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sikeston</u> 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>Mo. Delta Comm. Hosp.</u> Length of stay in 1b <u>7 Days</u>		d. STREET ADDRESS (If outside, give location) <u>Route # 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Willie</u> Last <u>Goodon</u>			4. DATE OF DEATH Month <u>9</u> Day <u>15</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>5-12-1880</u>
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Tennessee</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Goodon</u>	
14. MOTHER'S MAIDEN NAME <u>Opal Horton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ruby Goodon</u> Address <u>Sikeston, 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>Cerebral Hemorrhage</u> 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(n) <u>331x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" 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.)		20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	
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.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>9-9-57</u> to <u>9-15-57</u> and last saw her/him alive on _____ Death occurred at <u>2:10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. M. Jaxo M.D.</u>		22b. ADDRESS <u>Molhause, Mo.</u>	
22c. DATE SIGNED <u>9-21-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>9-17-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>	
23d. LOCATION (City, town, or county) <u>Sikeston, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>J. C. Casady</u> ADDRESS <u>Ninety One Funeral Chapel</u> <u>Sikeston, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>9-21-57</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Edna F. Hunter</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

DATE RECEIVED SEP 23 1957

SCOTT CO. HEALTH DEPT.

CO. FILE NO. 957-202

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Philip J. Cassidy*

Licensed Embalmer No. 461

P. O. Address Sikeston,

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.