

Health,
& Welfare
Public
Service

FILED MAR 10 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47731

STATE FILE NUMBER

Registration District No. 241 Primary Registration District No. 5-829 Registrar's No. 7

S. 300
7. 1-57
0720

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jay Wye Portage Twp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jay Wye</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt. 1 Portageville</u>		Length of stay in lb <u>20 Yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Rt. 1 Portageville</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Nellie Goosenberry</u>			4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1957</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>May 30, 1874</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Rt. 1 Caruthersville, Mo. Stubtown, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Stubbs</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Goosenberry</u>		14. NAME OF HUSBAND OR WIFE <u>X</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>None</u>	17. INFORMANT Address <u>Mrs. Mary Bland Rt. 1 Portageville, 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>Coronary Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio Sclerosis</u>					} <u>5 years</u>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</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 _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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>3-7-52</u> to <u>12-28-57</u> and last saw her alive on <u>12-28-57</u> . Death occurred at <u>8</u> P.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>James O. Cannon D.O.</u> (Degree or title)			22b. ADDRESS <u>Boonville, Mo.</u>		22c. DATE SIGNED <u>2-22-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 30, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Caruthersville, Missouri</u>
24. FUNERAL DIRECTOR <u>H.S. Smith Funeral Home C'ville, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-27-58</u>	26. REGISTRAR'S SIGNATURE <u>Ellen DeGale Orlem</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

DATE RECEIVED MAR 5 1958
NEW MADRID CO. HEALTH CENTER
P. G. S.

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 W. Sewer Pike

Licensed Embalmer No. 4484
P. O. Address Caruthersville

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.