. Health,
. & Welfare
. Public
th Service

S. 300
. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-028804
STATE FILE NUMBER

FILED SEP 2 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 836

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Springfield — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Johns Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Greene
c. CITY OR TOWN: Springfield 0396 0 — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): 412 E. Commercial — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: John Middle: L. Last: Goodman

4. DATE OF DEATH Month: August Day: 25 Year: 1958

5. SEX: Male d

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [XX] DIVORCED [ ]

8. DATE OF BIRTH: 1 Nov. 1888

9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Conductor

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (City and state or country): Arkansas 1

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: J.L.Goodman

13b. MOTHER'S MAIDEN NAME: NancyPenix

14. NAME OF HUSBAND OR WIFE: Widowed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 4201
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 [X] NO [ ] 1

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 8-23-58, to 8-25-58 and last saw ~~her~~ him alive on 8-25-58
Death occurred at 3:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [illegible] (Degree or title) MD

22b. ADDRESS 609 Cherry Springfield, Mo.

22c. DATE SIGNED 8-26-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8-28-58

23c. NAME OF CEMETERY OR CREMATORY: National

23d. LOCATION (City, town, or county) (State): Springfield, Mo.

24. FUNERAL DIRECTOR: Jay Klingner & Co. ADDRESS: Spgfd. Mo.

25. DATE RECD. BY LOCAL REG.: 8-28-58

26. REGISTRAR'S SIGNATURE: Effie G. Mellon

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. .....
P. O. Address .....

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.