Health, & Welfare Public Service

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S. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-044841
STATE FILE NUMBER

FILED DEC 16 1958 Registration District No. 195 Primary Registration District No. Registrar's No. 102-58

1. PLACE OF DEATH a. COUNTY McDonald	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY McDonald
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) JANE — Inside Limits Yes ☑ No ☐	c. CITY OR TOWN JANE 6600 0 — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Home — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Sylvanus	Middle:	Last: Goodnight	4. DATE OF DEATH Month: Nov.	Day: 8	Year: -58		
5. SEX: M 0	6. COLOR OR RACE: W	7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 8-26-1880	9. AGE (In years at last birthday): 78	IF UNDER 1 YEAR Months: 2	Days: 12	IF UNDER 24 HRS. Hours:	Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER	10b. KIND OF BUSINESS OR INDUSTRY: RET.	11. BIRTHPLACE (City and state or country): KENTUCKY	12. CITIZEN OF WHAT COUNTRY? U.S.				
13a. FATHER'S NAME: Rufus Goodnight	13b. MOTHER'S MAIDEN NAME: Francis Tabb	14. NAME OF HUSBAND OR WIFE: Luha Goodnight					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): No	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Coy Goodnight	Address: JANE, Mo			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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) Cardio-Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

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 (a): 442X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

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 Aug 8 58, to Nov 4 58 and last saw ~~her~~ him alive on Nov 4 58

Death occurred at 6:30 am m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Sec Blessed DO 2

22b. ADDRESS: Purcelle Mo

22c. DATE SIGNED: 12/8/58

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

23b. DATE: 11-10-58

23c. NAME OF CEMETERY OR CREMATORY: White Rock Cem

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

24. FUNERAL DIRECTOR: Humphrey & Son

ADDRESS: Purcelle, Mo

25. DATE RECD. BY LOCAL REG.: 12/8/58

26. REGISTRAR'S SIGNATURE: Mary G. Bradley

(Licensed Embalmer's Statement on Reverse Side)

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 F. M. Humphrey Jr.

Licensed Embalmer No. 4708

P. O. Address Noel, Ms.

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.