

pt. Health,
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-60-007192

STATE FILE NUMBER

FILED VS FEB 29 1960

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CHILlicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MEADVILLE 0580</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>SUSAN'S NURSING HOME 1HR</u> HOSPITAL OR INSTITUTION		Length of stay in 1b <u>8 1/2</u>	d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>GERTRUDE</u> Last <u>GOODMAN</u>			4. DATE OF DEATH Month <u>2</u> Day <u>-21</u> Year <u>60</u>		
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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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1878</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>_____</u>	11. BIRTHPLACE (City and state or country) <u>MEADVILLE, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>JOHN AILOR</u>	13b. MOTHER'S MAIDEN NAME <u>BETTY MARTIN</u>	14. NAME OF HUSBAND OR WIFE <u>CHARLES</u>
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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>_____</u>	17. INFORMANT <u>Mrs OTTO STECK, OVERLAND PARK, KANSAS</u> Address
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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>Acute coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 P.M.</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized arteriosclerosis

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)
Senility

19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>_____</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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.) <u>_____</u>	20f. CITY, TOWN, OR LOCATION <u>_____</u>	COUNTY <u>_____</u>	STATE <u>_____</u>
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21. I attended the deceased from <u>2/19/60</u> to <u>2-19-60</u> and last saw her <u>alive on 2-19-60</u> . Death occurred at <u>4:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>A. W. Bohm M.D.</u> (Degree or title)	22b. ADDRESS <u>Brookfield Mo.</u>	22c. DATE SIGNED <u>2/23/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-23-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TOOF CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>LINNEUS, Missouri</u>
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24. FUNERAL DIRECTOR <u>BROTHERS, MEADVILLE, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2/23/60</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Reed</u>
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(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

MEDICAL CERTIFICATION

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 *M. R. Knight*

Licensed Embalmer No. *4655*

P. O. Address *Leadville, Mo.*

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.