

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4921-63-017657  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

**FILED MAY 9 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4538 Parkview</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>M.</b> Last <b>GOFF</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>5</b> Year <b>1963</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/1892</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Bernie, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>Frank Higginbottom</b>		13b. MOTHER'S MAIDEN NAME <b>Pearl Greathouse</b>		14. NAME OF HUSBAND OR WIFE <b>Robert Goff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Robert Goff, 4538 Parkview</b>		

18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>		<b>12 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>	<b>Unk.</b>
	DUE TO (c) <b>4200</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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. Month, Day, Year _____	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 <b>1/26/54</b> to <b>5/5/63</b> and last saw her alive on <b>5/5/63</b> Death occurred at <b>4:50 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W. J. Miller, M.D.</i>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>5/5/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-7-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Bernie, Mo.</b>
24. FUNERAL DIRECTOR <b>Watkins Funeral Home, Dexter, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 6 1963</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

VS 300 Rev. 4/59  
 1  
 2 **2/18/63**  
 3  
 4 **1**  
 5 **1**  
 6  
 7 **0**  
 8 **2**  
 9  
 10  
 11  
 12 **52-0**  
 13  
 52  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DATE AMENDED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 USE BLACK INK OR TYPEWRITER RIBBON

**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 Elton R. Penelumb

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.