

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031125

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 370 Primary Registration District No. 6255 Registrar's No. 112

FILED AUG 12 1963

VS 300	DATE AMENDED
Rev. 4/59	
1 1110	
2 1110	
3	
4 0	
5 3	
6	
7 1	
8 0	
9 420.1	
10	
11	
12 90-0	
13 20	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>WAYNE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WAYNE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COWAN TWP.</u> Length of stay in 1b <u>14 YRS</u>		c. CITY OR TOWN (YEAR) <u>LOWNDES MO. RR</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>(NEAR) LOWNDES MO RR</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) * <u>R.F.D. LOWNDES, MO.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>HUGH R. GOODRICH</u>			4. DATE OF DEATH Month Day Year <u>AUG. 6, 1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-13-1887</u>
9. AGE (last birthday) <u>76-1-13</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SMITH-BRIDGEMAN FLINT MICH.</u>	11. BIRTHPLACE (City and state or country) <u>ATLAS, MICH.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JAMES GOODRICH</u>	
13b. MOTHER'S MAIDEN NAME <u>CLARA DEWSTONE</u>		14. NAME OF HUSBAND OR WIFE <u>DEWROLD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates) <u>NO</u>		16. SOCIAL SECURITY NO. <u>910 Romaine Elenor Rogers</u>	17. INFORMANT Address <u>LOWNDES MO</u>
18. CAUSE OF DEATH (Enter only one cause per part) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion subcor</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>San Patient Home</u> and last saw her/him alive on <u>Day & time</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>L.S. Rowe M.D.</u>		22b. ADDRESS <u>321 Oak St. Flint Mich</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>8-8-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GOODRICH</u>	23d. LOCATION (City, town, or county) (State) <u>FLINT MICH</u>
24. FUNERAL DIRECTOR <u>GISH FUNERAL HOME</u>		ADDRESS <u>FLINT MO</u>	25. DATE RECD. BY LOCAL REG. <u>8-8-63</u>
26. REGISTRAR'S SIGNATURE <u>Hethorn. Ward</u>			

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 me Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Marion E. Douke

Licensed Embalmer No.

4426

P. O. Address

Piedmont, Va.

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.