

No. 300
10-48
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FILED MAR 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9237

BIRTH NO. 49-016502 REG. DIST. NO. 211 PRIMARY REG. DIST. NO. 4324 Registrar's No. 3-49

1. PLACE OF DEATH a. COUNTY Miller		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Miller 06	
b. CITY OR TOWN Tuscombria		c. CITY OR TOWN Lake Ozark 0	
c. LENGTH OF STAY (in this place) 14 day		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Humphrey's Hospital 0			

3. NAME OF DECEASED (Type or Print) a. (First) Judy b. (Middle) ANN c. (Last) Goode			4. DATE OF DEATH (Month) (Day) (Year) March 3 1949		
5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 0	
8. DATE OF BIRTH Feb. 17, 1949		9. AGE (In years last birthday) 0		10. IF UNDER 1 YEAR: Months 14 Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Missouri 0	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Glen Goode		13b. MOTHER'S MAIDEN NAME Adele Crowson		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Glen Goode Lake Ozark	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity Respiratory failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) failure DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 776X			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? none	

22. I hereby certify that I attended the deceased from Feb 17, 1949, to March 3, 1949, that I last saw the deceased alive on Mar 3, 1949, and that death occurred at 8:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE M. E. Humphreys J.D.O.		(Degree or title)		23b. ADDRESS Tuscombria Mo		23c. DATE SIGNED 4 Feb 49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4 Feb 49		24c. NAME OF CEMETERY OR CREMATORY River View Cem		24d. LOCATION (City, town, or county) (State) Miller Co Mo	

DATE REC'D BY LOCAL REG. March 11-49		REGISTRAR'S SIGNATURE Mrs. Richard L. Wright		25. FUNERAL DIRECTOR'S SIGNATURE Faith M. Kayser		ADDRESS ELDON	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District No. _____
MAR 16 1949
Date Filed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{Not} embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Keith McKay*

Licensed Embalmer No. 3998

P. O. Address Eldon 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 this body is not embalmed, fact should be so stated above.