

FILED AUG 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22600

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 857

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 723 So. 11th St.		d. STREET ADDRESS (If rural, give location) 723 So. 11th St.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) STONEWALL	b. (Middle) JACKSON	c. (Last) GOODPASTER	(Month) 8	(Day) 3	(Year) 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4-1-1868	9. AGE (In years last birthday) 81	10. MONTHS 1	11. DAYS 1	12. HOURS 1	13. MIN. 1
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Bath Co., Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Amanda Goodpaster
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carroll Goodpaster, Dearborn, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		DUE TO (b) Arteriosclerosis		1 yr
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		4 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		_____		4:50

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 11, 1949, to Aug 3, 1949, that I last saw the deceased alive on July 28, 1949, and that death occurred at 6:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Clarence C. Johnson M.D.</i>	23b. ADDRESS The Schneider Bldg. St. Joseph, Missouri	23c. DATE SIGNED 8-4-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-4-1949	24c. NAME OF CEMETERY OR CREMATORY Turner Cemetery	24d. LOCATION (City, town, or county) (State) Wallace, Missouri
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DATE REC'D BY LOCAL REG. Aug. 5, 1949	REGISTRAR'S SIGNATURE <i>H. G. Jenkins</i>	382	FUNERAL DIRECTOR'S SIGNATURE <i>Blue C. Kupp</i>	ADDRESS <i>St. Joseph, Mo.</i>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

John E. Rupp

Signed _____
Student Embalmer

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, Mo.*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.