

No. 300
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FILED JAN 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3615

BIRTH NO. _____		REG. DIST. NO. 354		PRIMARY REG. DIST. NO. 4519		Registrar's No. 13	
1. PLACE OF DEATH a. COUNTY TEXAS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY TEXAS			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CABOOL			c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CABOOL			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) MARY		a. (First)		b. (Middle) W.		c. (Last) * GOODE	
4. DATE OF DEATH		5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH NOV. 27, 1867		9. AGE (In years last birthday) 83		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME VANDIVORT		13b. MOTHER'S MAIDEN NAME HOWELL	
14. NAME OF HUSBAND OR WIFE FOUNTAIN GOODE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Lee Cunningham West Plains	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 30 minutes 4 1/2 hr	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) COUNTY STATE Cabool Texas MO			
21d. TIME OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:30 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Gayland V. Elliott (Degree or title)				23b. ADDRESS Cabool MO		23c. DATE SIGNED Jan 6, 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Jan 9, 1950		24c. NAME OF CEMETERY OR CREMATORY Cabool Cemetery		24d. LOCATION (City, town, or county) (State) Cabool MO	
DATE REC'D BY LOCAL REG. 1-10-50		REGISTRAR'S SIGNATURE Gaynell Cunningham		25. FUNERAL DIRECTOR'S SIGNATURE Gayland V. Elliott		ADDRESS Cabool	

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

Recd
Jan
1-6
9:0

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
Student Embalmer

Student Embalmer No. _____

Signed

Gayford V Elliott

Licensed Embalmer No. *2252*

P. O. Address

Cabool 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.