

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

16374

State File No. ....

No. 300  
10-48

FILED MAY 28 1951

460

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

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>5550</u>		Registrar's No. <u>28</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> COUNTY <u>Howell</u>			
b. CITY OR TOWN <u>Howell</u>		c. LENGTH OF STAY (in this place) <u>6 1/2 yrs</u>		c. CITY OR TOWN <u>Howell</u>		d. STREET ADDRESS <u>no</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>				d. STREET ADDRESS (If rural, give location) <u>no</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Linne</u>			b. (Middle) <u>Belle M</u>			c. (Last) <u>Goldrick</u>	
4. DATE OF DEATH		(Month) <u>4</u>		(Day) <u>18</u>		(Year) <u>51</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-3-1887</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Month <u>7</u> Day <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Howell Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Gas. Story</u>			13b. MOTHER'S MAIDEN NAME <u>Cynthia</u>			14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y for no. or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <u>Bob M Goldrick</u>		ADDRESS <u>Howell, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		<b>MEDICAL CERTIFICATION</b>					INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential Hypertension</u>					<u>yes</u>
		DUE TO (c) <u>Chronic degenerative nephritis</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>592x</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 <u>9-18-47</u> , 19 <u>47</u> , to <u>4-18</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4-17</u> , 19 <u>51</u> , and that death occurred at <u>9:45</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Daniel R. Sump D.D.</u>			23b. ADDRESS <u>Bakersfield, Mo.</u>			23c. DATE SIGNED <u>4-24-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>4-20-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wellerorville</u>		24d. LOCATION (City, town, or county) (State) <u>Wellerorville Mo</u>	
DATE REC'D BY LOCAL REG. <u>5-14-51</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert W. Nestham</u>		ADDRESS <u>Mo</u>	

DIVISION OF HEALTH OF MD.  
District No. 5 - Springfield

RECEIVED MAY 21 1951

Dist. File 257-91710

Date Filed 5-22-51

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 .....

Student Embalmer

Signed

*J. S. Roberts*

Licensed Embalmer No. 3437

P. O. Address West Hill

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.