

DR. WAKEMAN
STANDARD CERTIFICATE OF DEATH

State File No. **24490**
 Registrar's No. **670**

FILED JUL 27 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5465**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY TANEY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN NICHOLS JUNCTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN TANEYVILLE	
c. LENGTH OF STAY (In this place) 2 MO.		d. STREET ADDRESS (If rural, give location) 1060 / 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION DUNCAN REST HOME			

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) JACOB	b. (Middle) F.	c. (Last) GOETZ	(Month) JULY (Day) 18 , (Year) 1953

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH SEPT. 9 1866	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY MALE NURSE	11. BIRTHPLACE (State or foreign country) TANEYVILLE, MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME FRENK JOSEPH GOETZ	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown	17. INFORMANT'S SIGNATURE OR NAME DUNCAN REST HOME RECORDS	ADDRESS SPFLD, MO
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Senility		
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	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) (Min.)	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 **March 1953** to **July 18, 1953**, that I last saw the deceased alive on **July 10, 1953**, and that death occurred at **10:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE J. Newton Wakeman, M.D.	(Degree or title) M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 7-21-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7/18/53	24c. NAME OF CEMETERY OR CREMATORY BLAIR CEMETERY	24d. LOCATION (City, town, or county) (State) RUETER, MISSOURI
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DATE REC'D BY LOCAL REG. 7-21-53	REGISTRAR'S SIGNATURE Earl Williams	25. FUNERAL DIRECTOR'S SIGNATURE H.H. LOHMEYER	ADDRESS SPRINGFIELD, MO.
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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 A. J. MacCann

Licensed Embalmer No. 2727

P. O. Address Springfield 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.