

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2693**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN JEFFERSON BARRACKS, MO.)		c. CITY OR TOWN RICHMOND HEIGHTS	
c. LENGTH OF STAY (in this place) 10 DAYS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS (If rural, give location) 1404 WOODLAND DRIVE	

3. NAME OF DECEASED (Type or Print)	a. (First) SHAW	b. (Middle) L.	c. (Last) GOOLSBY	4. DATE OF DEATH (Month) (Day) (Year) 10-18-53
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 4-17-1890	9. AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTION PICTURE OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY ENTERTAINMENT	11. BIRTHPLACE (City and State or Foreign Country) SHERIDAN, ARK.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME LEVI CHARLES GOOLSBY	13b. MOTHER'S MAIDEN NAME MELINDA SHAW	14. NAME OF HUSBAND OR WIFE FLOY M. GOOLSBY
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) YES	16. SOCIAL SECURITY NO. WH-1	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF. BRKS., MO.	ADDRESS _____
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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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL THROMBOSIS WITH CEREBRAL ATROPHY		1 YR.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CEREBRAL ARTERIOSCLEROSIS		18 MOS.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		334X	

19a. DATE OF OPERATION NONE	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, etc.)	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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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? _____
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22. I hereby certify that I ^{VA} attended the deceased from **10-8**, 19 **53**, to **10-18**, 19 **53**, ~~and that death occurred at 7:30 p.m., from the causes and on the date stated above.~~

23a. SIGNATURE H. V. Hartman	(Degree or title) M.D.	23b. ADDRESS VET. ADM. HOSPITAL, JEFF. BRKS, MO.	23c. DATE SIGNED 10-18-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-19-53	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Sheridan, Arkansas
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DATE REC'D BY LOCAL REG. 10/19/53	REGISTRAR'S SIGNATURE Herbert R. ...	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington.
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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
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John S. Hem*.....
Licensed Embalmer No.....
P. O. Address *St. L.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.