

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

572

BIRTH NO. FILED FEB 10 1954 REG. DIST. NO. 69 PRIMARY REG. DIST. NO. 4122 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY Christian		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Missouri b. COUNTY Christian	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nixa	c. LENGTH OF STAY (In this place) 35 Yrs.	c. CITY OR TOWN Nixa	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 Home		e. STREET ADDRESS (If rural, give location) No Street Address	

3. NAME OF DECEASED (Type or Print) MAUDE M. GODDARD			4. DATE OF DEATH (Month) (Day) (Year) Jan. 29-1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 25, 1883	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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 (City and State or Foreign Country) / Henrietta, Texas		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John E. Harris	13b. MOTHER'S MAIDEN NAME Mary A. Robison	14. NAME OF HUSBAND OR WIFE James H. Goddard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Carolyn Crane, Monett, Mo.

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) Hyperstatic pneumonia		DUPLICATE		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes m.		
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.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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?

22. I hereby certify that I attended the deceased from **2-16, 1950**, to **1-29, 1954**, that I last saw the deceased alive on **1-25, 1954**, and that death occurred at **1030a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Harold Shaffer	(Degree or title)	23b. ADDRESS Nixa, Mo.	23c. DATE SIGNED 1-30-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-31-1954	24c. NAME OF CEMETERY OR CREMATORY Payne Cemetery	24d. LOCATION (City, town, or county) (State) Nixa, Missouri

DATE REC'D BY LOCAL REG. Feb. 4, 1954	REGISTRAR'S SIGNATURE Allie Deier	25. FUNERAL DIRECTOR'S SIGNATURE John H. Harris	ADDRESS Clever, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0. 300
0. 48

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.....
Signature of Student Embalmer

Signed..... *John Dean Harris*.....

Licensed Embalmer No..... *438*.....

P. O. Address..... *Cleveland*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.