

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2817

FILED FEB 2 1954

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State File No. 0343  
Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>Dupo</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>16 days</u>		e. STREET ADDRESS (If rural, give location) <u>329 N. 4th.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u> b. (Middle) <u>EMMETT</u> c. (Last) <u>GOFORTH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 13 - 1954</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>November 11, 1901</u>
9. AGE (In years last birthday) <u>52</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Locomotive Engineer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Pickneville, Illinois</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. R.R.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>William A. Goforth</u>		13b. MOTHER'S MAIDEN NAME <u>Margret Luby</u>	14. NAME OF HUSBAND OR WIFE <u>Ora (Carter) Goforth</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>702-16 5164</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ora Goforth</u> ADDRESS <u>Dupo, Illinois</u>	
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.			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Adeno Carcinoma transverse Colon -</u>			<u>30 days</u>
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. <u>Post operative - intestinal distention -</u>			<u>6 days</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Adeno Carcinoma - transverse Colon -</u>		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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>153x</u>	
22. I hereby certify that I attended the deceased from <u>18 Dec., 1953</u> , to <u>13 Jan., 1954</u> , that I last saw the deceased alive on <u>12 JAN., 1954</u> , and that death occurred at <u>3:15 AM.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Henry Saffner M.D.</u>		23b. ADDRESS <u>3720 Washington</u>	23c. DATE SIGNED <u>13 Jan 54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 17, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>B. Mount Pleasant</u>	24d. LOCATION (City, town, or county) (State) <u>Iuka, Illinois</u>
DATE REC'D BY LOCAL REG. <u>JAN 18 1954</u>	REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>David ...</u>	ADDRESS <u>Dupo, Illinois</u>

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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..... *Harold A. Pedman*

Licensed Embalmer No.?

P. O. Address *Reps. St.*

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.