

FILED JUL 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21160**BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **702**

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Buchanan						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) Over 50 yr	c. CITY OR TOWN St. Joseph		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION General Osteopathic Hospital			e. STREET ADDRESS (If rural, give location) 2822 Angelique Street						
3. NAME OF DECEASED (Type or Print) a. (First) ADOLPHUS			b. (Middle) G	c. (Last) GOUDIE	4. DATE OF DEATH (Month) (Day) (Year) July 10 1955				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 17, 1870		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 12 HRS. Hours	IF UNDER 12 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (City and State or Foreign Country) Taylor County Iowa		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME John Sherman Goudie			13b. MOTHER'S MAIDEN NAME Emaline Rawlings		14. NAME OF HUSBAND OR WIFE Alice May Goudie (Deceased)				
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. 491-24-9825-A	17. INFORMANT'S SIGNATURE OR NAME Vern W. Snider		ADDRESS St. Joseph, Mo.				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Arteriosclerosis, Arteriosclerosis 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. H201					INTERVAL BETWEEN ONSET AND DEATH 12 hr			
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) m.	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 7-10-55 , 19____, to 7-10-55 , 19____, that I last saw the deceased alive on 7-10-55 , 19____, and that death occurred at 8:00P m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) C. J. Ferguson			23b. ADDRESS 180 E. Francis St. City		23c. DATE SIGNED 7-12-55				
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 13, 1955	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph Missouri					
DATE REC'D BY LOCAL REG. July 15, 1955	REGISTRAR'S SIGNATURE Kathleen M. Allison		FUNERAL DIRECTOR'S SIGNATURE Stammy Funeral Home		ADDRESS St. Joseph, Mo.				

(Licensed Embalmer's Statement on Reverse Side)

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 *Charles E. Bennett*.....

Licensed Embalmer No. *216*

P. O. Address *St. Joseph*

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.