

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 5 - 1955

State File No. **30470**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **298** PRIMARY REG. DIST. NO. **6024** Registrar's No. **8**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>RAY</b>                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>RAY</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>ELMIRA</b> |  | c. CITY OR TOWN <b>ELMIRA</b>   |  |
| c. LENGTH OF STAY (in this place) _____  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>RURAL RT. #1, LAWSON, Mo.</b>       |  |   |  |
| f. STREET ADDRESS (If rural, give location) <b>1/2 MILE EAST, ELMIRA, Mo.</b>  |  |   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 3. NAME OF DECEASED<br>a. (First) <b>RANDALL</b> b. (Middle) <b>ROBERT</b> c. (Last) <b>GODLEY</b>      |  |   | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>SEPT. 19 1955</b> |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>                 |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b> |  |
| 8. DATE OF BIRTH <b>JAN. 12, 1954</b>   |  | 9. AGE (In years last birthday) <b>1</b>      |  | 10. IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b>                    |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <b>EXCELSIOR SPRINGS, Mo.</b>                        |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>       |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b> |  |  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME <b>ROBERT GODLEY</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>WANDA O'DELL</b> |  | 14. NAME OF HUSBAND OR WIFE <b>NONE</b>                                     |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> |  | 16. SOCIAL SECURITY NO. <b>NONE</b>           |  | 17. INFORMANT'S SIGNATURE OR NAME <b>ROBERT GODLEY, Rt. #1, LAWSON, Mo.</b> |  |
|  |  |   |  | ADDRESS   |  |

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, 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) <b>Drowning</b>  |  | ANTECEDENT CAUSES   |  |  |  |  |  |
|   |  | DUE TO (b) <b>Fell in the Well</b>  |  |  |  |  |  |
|   |  | DUE TO (c)  |  |  |  |  |  |
| 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 <b>9290</b>  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 21a. ACCIDENT (Specify) <b>accident</b>                              |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>              |  | 21c. (CITY, TOWN, OR TOWNSHIP) <b>Gloria</b> (COUNTY) <b>Ray</b> (STATE) <b>Mo</b> |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>9-19-55 11 AM</b> |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? _____   |  |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|  |  |                              |  |   |  |
|--|--|------------------------------|--|---|--|
| 23a. SIGNATURE (Degree or title) <b>D. H. John F. Baker, Coroner</b> |  | 23b. ADDRESS <b>Ray, Mo.</b> |  | 23c. DATE SIGNED <b>9-19-55</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>              |  | 24b. DATE <b>9-21-55</b>     |  | 24c. NAME OF CEMETERY OR CREMATORY <b>CROWN HILL</b>                        |  |
|  |  |                              |  | 24d. LOCATION (City, town, or county) (State) <b>EXCELSIOR SPRINGS, Mo.</b> |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <b>Sept. 29, 1955</b> |  | REGISTRAR'S SIGNATURE <b>Mrs. Raymond H. ...</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Glaude ...</b> |  |
|  |  |  |  | ADDRESS <b>Excelsior Springs, Mo.</b>              |  |

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

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 *Lynzee Jarman* .....

Licensed Embalmer No. *450*  
P. O. Address *Excelsior Springs,* .....

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.