

No. 300  
10-48

FILED JAN 5 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41434**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **240** PRIMARY REG. DIST. NO. **5826** Registrar's No. **43**

1. PLACE OF DEATH a. COUNTY <b>NEW MADRID</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> COUNTY <b>NEW MADRID</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>MARSTON</b>		c. CITY OR TOWN <b>MARSTON</b>	
c. LENGTH OF STAY (in this place) <b>18 yrs</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>RESIDENCE, GEN. DEL.</b>		e. STREET ADDRESS (If rural, give location) <b>8726</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ADA</b>	b. (Middle) <b>MAY</b>	c. (Last) <b>GOODE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>NOV. 13, 1955</b>
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5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>AUG. 30, 1879</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>HENDERSON CO., KY.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>UNKNOWN</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>EDWARD L. GOODE</b>
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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>J. W. Goode - Wardell, Mo.</b>	ADDRESS _____
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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, 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>acute cardiac decompensation</b>		<b>24 hours</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>acute gastric spasm</b>		<b>24 hours</b>
DUE TO (c) <b>Chronic gall bladder disease</b>		<b>10 years</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>hypertension with arrhythmia</b>		<b>3 years</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>586x</b>	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, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-3-1952** to **11-13, 1955**, that I last saw the deceased alive on **11-13, 1955**, and that death occurred at **9:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. W. Goode - Wardell</b> (Degree or title)	23b. ADDRESS <b>Marston - Mo.</b>	23c. DATE SIGNED <b>12-29-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>11-14-55</b>	24c. NAME OF CEMETERY, OR CREMATORY <b>MATTHEW'S</b>	24d. LOCATION (City, town, or county) (State) <b>MATTHEW'S MO.</b>
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DATE REC'D BY LOCAL REG. <b>12-31-55</b>	REGISTRAR'S SIGNATURE <b>H. L. Gonder Deputy</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Shelby</b>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 9 1955

DATE RECEIVED JAN 3 1955  
NEW MADRID CO. HEALTH CENTER

P. J. S.

**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 Ernie Shelby.....

Licensed Embalmer No. 27.....

P. O. Address East........

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.