

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4331

State File No.

FILED MAR 5 1956

BIRTH NO. _____		REG. DIST. NO. <u>119</u>		PRIMARY REG. DIST. NO. <u>4191</u> Registrar's No. <u>2</u>	
1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u>			2. USUAL RESIDENCE (Where deceased lived. Institution: residence before death) a. STATE <u>Mo</u> b. COUNTY <u>GASCONADE</u>		
b. CITY (If outside corporate limits, write RURAL and give town or city) <u>GASCONADE</u>		c. LENGTH OF STAY (In this place) <u>2 1/2 yrs</u>	c. CITY OR TOWN <u>GASCONADE</u>		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 _____			e. STREET ADDRESS (If rural, give location) _____ <u>037 1/2</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>NUMA</u> b. (Middle) <u>Esma</u> c. (Last) <u>Goodnight</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 2-1956</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>MAY 24-1892</u>		9. AGE (In years last birthday) <u>63</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work (One during most of working life, even if retired)) <u>RETIRED AUDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUDITING</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>BRIGHTON Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13a. FATHER'S NAME <u>DANIEL Goodnight</u>		13b. MOTHER'S MAIDEN NAME <u>ETTA JANCENSE</u>		14. NAME OF HUSBAND OR WIFE <u>Orphia Goodnight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Orphia Goodnight GASCONADE Mo</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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Symptoms: Apoplexy</u> ANTECEDENT CAUSES DUE TO (b) <u>(HAS BEEN IN BAD HEALTH PAST 2 1/2 YEARS)</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____ <u>334x</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>(NONE)</u>		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 _____, 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 <u>Herbert Hermann</u> (Degree or title) <u>CORONER</u>			23b. ADDRESS <u>HERMANN Mo</u>		23c. DATE SIGNED <u>2/3/56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2/5/1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GASCONADE CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>GASCONADE Mo</u>		
DATE REC'D BY LOCAL REG. <u>2-4-56</u>	REGISTRAR'S SIGNATURE <u>Delma</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert Hermann</u> ADDRESS <u>HERMANN Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 8 1958

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.....
Lugost-Lemus
Licensed Embalmer No. 216
P. O. Address *Herrmann*

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.