

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3954

STATE FILE NUMBER

FILED FEB 18 1957

1144-57

Registration District No.

53

Primary Registration District No.

3010

Registrar's No. 131

1. PLACE OF DEATH a. COUNTY <i>Cape County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Dunklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits TOWN <i>Cape Girardeau</i> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Malden</i> 0360	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St Francis Hsp</i> Length of stay in lb <i>1 Day</i>		d. STREET ADDRESS (If outside, give location) <i>402 So Decatur</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Calvin Ernest Golden</i>			4. DATE OF DEATH <i>2-1-57</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 30 - 57</i>	
9. AGE (In years last birthday) <i>—</i>		IF UNDER 1 YEAR Months <i>—</i> Days <i>3</i>	IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (City and state and country) <i>Kennett, Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>Us</i>		13. FATHER'S NAME <i>Ernest Golden</i>		
14. MOTHER'S MAIDEN NAME <i>Doris Faust</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Ernest Golden - Malden Mo</i> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural hematoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> <i>1 Day</i> <i>1 Day</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Intracranial hemorrhage</i>	
	DUE TO (c) <i>Bleeding disease of the Newborn</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>—</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Hour <i>—</i> Month, Day, Year <i>—</i> a. m. <i>—</i> p. m. <i>—</i>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>	
20e. CITY, TOWN, OR LOCATION <i>—</i>		COUNTY <i>—</i> STATE <i>—</i>

21. I attended the deceased from *1 Feb. 57* to *1 Feb. 57* and last saw *him* alive on *1 Feb. 57*
Death occurred at *8:30* *pm* on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Last name or title) <i>James A. Kinder M.D.</i>	22b. ADDRESS <i>Cape Girardeau, Mo.</i>	22c. DATE SIGNED <i>5 Feb. 57</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2-2-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Park Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Malden Mo</i>
24. FUNERAL DIRECTOR <i>Thomas C. Knight</i> ADDRESS <i>Malden Mo</i>	25. DATE RECD. BY LOCAL REG. <i>2-13-1957</i>	26. REGISTRAR'S SIGNATURE <i>T. C. Summers</i>	

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service
 300-56
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAY 15 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{NOT} embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Thomas C. Knight*

Licensed Embalmer No. *218*

P. O. Address *Malden*

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.