

death, welfare, public, service, diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28122

STATE FILE NUMBER

FILED AUG 19 1957

Registration District No.

137

Primary Registration District No.

3023

Registrar's No.

563

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Verona</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General</u>		Length of stay in lb <u>3 hrs</u>		d. STREET ADDRESS (If outside, give location) <u>RR # 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rodney</u> Middle <u>Leon</u> Last <u>Gooding</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 20-1934</u>			
9. AGE (In years last birthday) <u>22</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (City and state or country) <u>Rolla Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jay Gooding</u>				14. MOTHER'S MAIDEN NAME <u>Etta Hanson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>444-34-2768</u>		17. INFORMANT <u>Jay Gooding</u> Address <u>Verona Mo</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull fracture</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>9023</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
20a. ACCIDENT <input checked="" 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.) <u>Fell 35 ft. from construction boom.</u>					
20c. TIME OF INJURY Hour <u>8</u> Month <u>12</u> Day <u>57</u> a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Montrose Station</u>		20f. CITY, TOWN, OR LOCATION <u>Montrose,</u>		COUNTY <u>Henry</u> STATE <u>Mo.</u>			
21. I attended the deceased from <u>August 12</u> , to <u>**</u> and last saw her <u>him</u> alive on <u>August 12</u> Death occurred at <u>12</u> <u>NOON</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Deceased or Title) <u>James D. Smith MD</u>				22b. ADDRESS <u>106 S. Third</u>		22c. DATE SIGNED <u>8/12/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-14-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring River ccm</u>		23d. LOCATION (City, town, or county) (State) <u>Verona Mo</u>			
24. FUNERAL DIRECTOR <u>Sickman Dunning</u> ADDRESS <u>Clinton Mo</u>				25. DATE RECD. BY LOCAL REG. <u>8-12-57</u>		26. REGISTRAR'S SIGNATURE <u>Malcolm Bigum</u>			

(Licensed Embalmer's Statement on Reverse Side)

SEP

9 1957

AUG 21 1957

SEP

8 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.