

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**58-009101**

STATE FILE NUMBER

**FILED MAR 17 1958**

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 59

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>CALLAWAY</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FULTON</b>	a. STATE <b>MISSOURI</b>	b. COUNTY <b>KNOX</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. HOSPITAL #1</b>		c. CITY OR TOWN <b>LA BELLE</b>	d. STREET ADDRESS (If outside, give location)
Length of stay in 1b <b>7 yrs.</b>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>		
First <b>ROBERT</b> Middle <b>W.</b> Last <b>GOODWIN</b>			Month <b>MARCH</b> Day <b>3</b> Year <b>1958</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12-2-1872</b>		<b>9. AGE</b> (In years last birthday) <b>86</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>FARM</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>KNOX COUNTY, MISSOURI</b>	
<b>13. FATHER'S NAME</b> <b>DANIEL GOODWIN</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY SNELLING</b>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNK.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>UNK.</b>		<b>17. INFORMANT</b> <b>STATE HOSPITAL #1, FULTON, MO.</b>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH
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) <b>CHRONIC BRAIN SYNDROME DUE TO CEREBRAL ARTERIOSCLEROSIS</b>		<b>4201</b>

<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m. _____					

<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <b>STATE HOSPITAL #1</b> <b>Dec. 14, 50</b> <b>to</b> <b>Mar. 3-1958</b> <b>and last saw her alive on</b> <b>Mar. 3-58</b>		<b>Death occurred at</b> <b>10:25 p. m.</b> <b>on the date stated above; and to the best of my knowledge, from the causes stated.</b>			
<b>22a. SIGNATURE</b> <i>[Signature]</i> <b>ERWIN LEONHARDT, M.D.</b>			<b>22b. ADDRESS</b> <b>STATE HOSPITAL # 1</b>		<b>22c. DATE SIGNED</b> <b>3-4-58</b>

<b>23a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>3-6-58</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Knox City Cemetery</b>	<b>23d. LOCATION (City, town, or county)</b> (State) <b>Knox City Mo.</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Code Funeral Home La Belle Mo.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>March 14-1958</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All 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

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MAR 28 1958  
APR 3 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 *J. J. Ross*

Licensed Embalmer No. *25*

P. O. Address *Public*

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.