

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009673

STATE FILE NUMBER

FILED MAR 24 1958

Registration District No.

137

Primary Registration District No.

3023

Registrar's No.

756

1. PLACE OF DEATH

a. COUNTY

Henry

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Henry 6422

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Clinton

Inside Limits
Yes ☒ No ☐

c. CITY
OR
TOWN

Clinton

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Moore's Rest Home

Length of stay in lb
7 yrs.

d. STREET ADDRESS (If outside, give location)

901 N. 2nd

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

TOM

GOOD PASTER

4. DATE OF DEATH

March 17 1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Apr. 20-1882

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.
75 10 27 - -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (City and state or country)

Kentucky

12. CITIZEN OF WHAT COUNTRY?

USA

13a. FATHER'S NAME

John Goodpaster

13b. MOTHER'S MAIDEN NAME

Mattie Freeman

14. NAME OF HUSBAND OR WIFE

None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Address

Moore's Rest Home Records Clinton Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chronic myocarditis

INTERVAL BETWEEN ONSET AND DEATH

2 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

4222

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Bronchial asthma

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from
Death occurred at

4/13/58

P

to

3/17/58

and last saw

him alive on

3/16/58

to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

S.B. Hughes, M.D.

22b. ADDRESS

Clinton, Mo.

22c. DATE SIGNED

3/18/58

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

3/18/58

23c. NAME OF CEMETERY OR CREMATORY

MITCHELL + DOUGLAS, FARMOUNT Sterling Kentucky

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

SCHUBERT FUNERAL HOME CLINTON MO 3-18-58

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Mildred Bigum

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 F L Schaberg

Licensed Embalmer No. 4513
P. O. Address Clinton, Mo.

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.