Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-022949
STATE FILE NUMBER

FILED JUN 17 1958 Registration District No. 2-9-7 Primary Registration District No. 6022 Registrar's No. 58

1. PLACE OF DEATH
a. COUNTY Ray
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Township — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION Rayville, Missouri R.F.D. #1 — Length of stay in 1b 70 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Ray
c. CITY OR TOWN Rayville — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 2 miles NE Rayville — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Oather Middle Alvis Last Goodman
4. DATE OF DEATH Month Day Year June 9, 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1879 October 24,
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months 7 Days 16 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY General Farming
11. BIRTHPLACE (City and state or country) Ray County, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jesse W. Goodman
13b. MOTHER'S MAIDEN NAME Mary Clevenger
14. NAME OF HUSBAND OR WIFE Martha C. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 495-42-7716
17. INFORMANT Address Mrs. Martha Goodman, Rayville, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Inst
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) 4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 a.m. p.m. Month, Day, Year
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 5-8-58, to 6-9-58 and last saw ~~her~~ him alive on 6-8-58
Death occurred at 6:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas B. Cook M.A.
22b. ADDRESS Richmond Mo.
22c. DATE SIGNED 6/12/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE June 12, 1958
23c. NAME OF CEMETERY OR CREMATORY Lawson Cemetery
23d. LOCATION (City, town, or county) (State) Lawson, Missouri

24. FUNERAL DIRECTOR ADDRESS Quest-Lile Funeral Home Richmond, Missouri
25. DATE RECD. BY LOCAL REG. 6-13-1958
26. REGISTRAR'S SIGNATURE Mabel Jackson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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
XXX

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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.