Health, & Welfare Public Service
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-026590
STATE FILE NUMBER

FILED AUG 4 1958 Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 171

1. PLACE OF DEATH
a. COUNTY: Randolph
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Moberly — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Woodland Hosp — Length of stay in 1b: 3 Days

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

3. NAME OF DECEASED (Type or print): First: Josie Middle: Romjue Last: Goodding

4. DATE OF DEATH: Month: July Day: 25 Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Aug 22, 1882
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

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

13a. FATHER'S NAME: Andrew Romjue
13b. MOTHER'S MAIDEN NAME: Susan E. Roan
14. NAME OF HUSBAND OR WIFE: Dec.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No.
17. INFORMANT: Theo H. Goodding Address: Atlanta

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): Cardiac Respiratory Arrest; — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Toxemia of anesthesia — 45 mins
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I: Abscess Liver — Obstructive Jaundice — Acute HB
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 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 24 July to 25 July and last saw her/him alive on 25 July 1958
Death occurred at 1:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title) M.D.
22b. ADDRESS: Moberly Mo
22c. DATE SIGNED: Jul 28/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 28, 1958
23c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor Cem.
23d. LOCATION (City, town, or county) (State): Atlanta, Mo.

24. FUNERAL DIRECTOR: Lester Hutton ADDRESS: Macon Mo.
25. DATE RECD. BY LOCAL REG.: 7/28/58
26. REGISTRAR'S SIGNATURE: [illegible]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Only diseases, nomenclature in Item 18. No symptoms will be listed.

AUG 6 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 Billy L. Binder

Licensed Embalmer No. 5034

P. O. Address Macon

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.