

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028800
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 128 Primary Registration District No. 2700 Registrar's No. 805

1. PLACE OF DEATH a. COUNTY <u>Greene County</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>Springfield,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Aurora</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MARK OSTEOPATHIC HOSPITAL</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>111 W. College</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Vida Goostee Gallion</u>			4. DATE OF DEATH Month Day Year <u>Aug - 16 / 58</u>		
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/1889</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>77</u> Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Lexington, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Goostee</u>	13b. MOTHER'S MAIDEN NAME <u>Parolea Rathes</u>	14. NAME OF HUSBAND OR WIFE <u>- - - - -</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>yes</u>	17. INFORMANT Address <u>Mr. Woodrow Benton, 116 Hadley, Aurora, Mo.</u>
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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>Circulatory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8/16/58 3:43 p.m.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial infarction</u>	<u>unknown</u>
	DUE TO (c) <u>Coronary Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetic Mellitus and Ketosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour - Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>8/15/58</u> , to <u>8/16/58</u> and last saw ^{her} / _{him} alive on <u>8/16/58</u> Death occurred at <u>3:15 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Island Ed Welch DO 2</u>	22b. ADDRESS <u>703 E. Sunshine, Springfield, Missouri</u>	22c. DATE SIGNED <u>8/16/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/19/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Aurora, Mo.</u>
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24. FUNERAL DIRECTOR <u>Arnold's Funeral Home</u>	ADDRESS <u>Aurora, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-21-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Arvin P. Arnold*

Licensed Embalmer No. *4929*
P. O. Address *AURORA, Ill.*

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.