

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040858

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No. 243

Primary Registration District No. 4364

Registrar's No. 89

300
1-57

1. PLACE OF DEATH a. COUNTY Newton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY McDonald	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stella		c. CITY OR TOWN Anderson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardwell Memorial Hosp.		d. STREET ADDRESS (If outside, give location) in town	

3. NAME OF DECEASED (Type or print) First Jim Middle E. Last Goodwin			4. DATE OF DEATH Month October Day 25 Year 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1876	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 1 Days 22	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Unknown	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Leona Goodwin
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish American	16. SOCIAL SECURITY NO. None	17. INFORMANT Hosp. Records	Address
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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) myocardial Decompensation		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
DUE TO (b) chronic myocarditis		
DUE TO (c) _____		3 1/2
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ 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 Sept 15 58 to Oct 26 and last saw him alive on Oct 25 58 Death occurred at 10 A. M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Ed Mountain (Degree or title)	22b. ADDRESS noel mo	22c. DATE SIGNED Oct 25
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/25/58	23c. NAME OF CEMETERY OR CREMATORY Anderson Cemetery	23d. LOCATION (City, town, or county) (State) Anderson, Missouri
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24. FUNERAL DIRECTOR Popps Funeral Home Anderson Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. 11-2-58	26. REGISTRAR'S SIGNATURE Medard Moberly
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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.

JAN 19 1958

Date Filed
JAN 12 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 *Carl Rapp*

Licensed Embalmer No. *3458*

P. O. Address *Anderson, 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.