

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014098

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 206 Primary Registration District No. 4217 Registrar's No. 24

300
1-57

1. PLACE OF DEATH a. COUNTY <u>MADISON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>MARQUAND</u>		c. CITY OR TOWN <u>MARQUAND</u> <u>0620</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		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>WASHINGTON</u> Last <u>Goodson</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 29 1895</u>	9. AGE (in years last birthday) <u>63</u>	10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS.	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Glenallen Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Joel Goodson</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Priddy</u>		14. NAME OF HUSBAND OR WIFE <u>MARY Goodson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>142-10-9476</u>		17. INFORMANT <u>Henry W. Goodson Jr St Louis, Mo</u>	

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>acute congestive failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 2 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <u>Paroxysmal tachycardia</u> DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4331</u>		

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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		20e. COUNTY		20g. STATE	
--	--	------------------------------	--	-------------	--	------------	--

21. I attended the deceased from 12-19-58 to 4-23-59 and last saw ^{him} alive on 4-23-59
Death occurred at 2:45 P on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. W. DeLeyere D.O.</u> (Degree or title)		22b. ADDRESS <u>Fredericktown Mo</u>		22c. DATE SIGNED <u>4/25/59</u>	
--	--	---	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 26, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Tree Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ballinger County, Mo</u>	
--	--	------------------------------------	--	--	--	--	--

24. FUNERAL DIRECTOR <u>Cal. Homeny Marquand Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-27-1959</u>		26. REGISTRAR'S SIGNATURE <u>Florence Ricker</u>	
--	--	--	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUN 29 1959

AUG 28 1959

MAY 9 1959

FILE NO. 589-24

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 *Raymond B. Wilson*

Licensed Embalmer No. *4884*

P. O. Address *Fredensborg*

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.