

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017340
STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 489

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY WRIGHT		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SEYMOUR		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST JOHNS HOSP		Length of stay in 1b 1 DAY	d. STREET ADDRESS (If outside, give location) ROUTE 2		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SARAH P. GOSS			4. DATE OF DEATH Month Day Year MAY 5-16-59		
5. SEX FEMALE	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 JAN 8 1879 80		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days 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) WRIGHT Co. MO.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME WILLIAM NOVEAN		
14. MOTHER'S MAIDEN NAME MARY BROWN			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. —			17. INFORMANT Address MRS. JOHN BAILEY CEDARGAP, MO.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Measenteric Thrombosis					INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Auricular Fibrillation					5 yrs
DUE TO (c) Thyreotoxicosis					20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2520					19. WAS AUTOPSY PERFORMED? 2 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.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <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	
21. I attended the deceased from May 15 to May 16 and last saw her ^{her} _{him} alive on May 16 Death occurred at 8:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) E. A. Donahoe Jr. M.D.			22b. ADDRESS 406 Prof. Bldg. Springfield, Mo		22c. DATE SIGNED 5/19/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-18-59	23c. NAME OF CEMETERY OR CREMATORY SEYMOUR MASONIC CEMETERY		23d. LOCATION (City, town, or county) (State) WEBSTER CO. MO.
24. FUNERAL DIRECTOR ADDRESS Robert Bergman Seymour, Mo.			25. DATE RECD. BY LOCAL REG. 5-20-59		26. REGISTRAR'S SIGNATURE Effie K. Meeter

(Licensed Embalmer's Statement on Reverse Side)

00 56
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAR 28 1960

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..... *Max L Miller*

Licensed Embalmer No. *42*

P. O. Address. *Manassas*

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.