

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020393

State File No. ....

FILED JUN 22 1959

|  |  |  |  |   |   |  |  |
|--|--|--|--|---|---|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>38</u>   |  | PRIMARY REG. DIST. NO. <u>3006</u>  |   | Registrar's No. <u>263</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give town)<br><u>Columbia</u>  |  | c. LENGTH OF STAY (in this place)<br><u>5 yrs.</u>   |  | c. CITY OR TOWN <u>Columbia</u>   |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>624 N 7th Street</u>  |  |  |  | e. STREET ADDRESS (If rural, give location)<br><u>624 N. 7th Street</u>   |   |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Willard</u>   |  | b. (Middle) <u>W.</u>  |  | c. (Last) <u>Goslin</u>   |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>6/13/1959</u>  |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  |   | 8. DATE OF BIRTH<br><u>1/3/1868</u>  |  |
| 9. AGE (In years last birthday)<br><u>91</u>   |  | IF UNDER 1 YEAR<br>Months _____ Days _____   |  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Farmer</u>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>   |   | 11. BIRTHPLACE (City and State or Foreign Country) <input type="checkbox"/><br><u>Boone County Missouri</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |
| 13a. FATHER'S NAME<br><u>William Goslin</u>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Pauline Tucker</u> |   | 14. NAME OF HUSBAND OR WIFE<br><u>Birtie Goslin</u>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)<br><u>None</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Mrs Birtie Goslin Columbia Mo</u>   |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Senile Infirmit</u> |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 day</u><br><u>5 yr</u>  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |   | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><u>331x</u>  |   |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR?  |   |  |  |
| 22. I hereby certify that I attended the deceased from <u>11</u> 19 <u>54</u> to <u>6-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-13</u> 19 <u>59</u> and that death occurred at <u>6:50 p.m.</u> , from the causes and on the date stated above. |  |  |  |   |   |  |  |
| 23a. SIGNATURE <u>R. B. ...</u> (Degree or title) <input type="checkbox"/>   |  |  |  | 23b. ADDRESS <u>Columbia Mo</u>   |   | 23c. DATE SIGNED <u>6-15-59</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 24b. DATE<br><u>6/15/1959</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Memorial Park</u>  |   | 24d. LOCATION (City, town, or county) (State)<br><u>Columbia, Mo.</u>  |  |
| DATE REC'D BY LOCAL REG. OFFICE<br><u>June 15 1959</u>   |  | REGISTRAR'S SIGNATURE<br><u>Mrs R E Palmer</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Lyman Sprinkle, Columbia, Mo.</u>  |   |  |  |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. David ...

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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 *Lynnard Sprinkle*  
Licensed Embalmer No. *4013*  
P. O. Address *Columbia*

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.