RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 13 1959

59–031872
STATE FILE NUMBER

Registration District No. 098 Primary Registration District No. _____ Registrar's No. 83

1. PLACE OF DEATH
a. COUNTY DAVIESS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN GALLATIN
Length of stay in 1b 2 weeks 4 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SULLIVAN REST HOME
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY DAVIESS
c. CITY OR TOWN WINSTON
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ROSA Middle JANE Last GOODING

4. DATE OF DEATH Month 10 Day 4 Year 1959

5. SEX F
6. COLOR OR RACE W
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 11-13-1871
9. AGE (last birthday) 87
IF UNDER 1 YEAR Months 10 Days 21
IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) MORGANVILLE KANS
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME ENOS LEE
13b. MOTHER'S MAIDEN NAME MARY WILSON
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT RUBIN GOODING Address KIDDER, MO. RR

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
INTERVAL BETWEEN ONSET AND DEATH 23 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Sept 18. 59 to Oct 4 59 and last saw her alive on Oct 3. 59
Death occurred at 9:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Fred W. Wilson (Degree or title) MD
22b. ADDRESS Winston Mo.
22c. DATE SIGNED 10/5/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 10-6-1959
23c. NAME OF CEMETERY OR CREMATORY WINSTON
23d. LOCATION (City, town, or county) WINSTON (State) MO

24. FUNERAL DIRECTOR Virgil V. Stroup ADDRESS Winston, Mo
25. DATE RECD. BY LOCAL REG. 10-6-1959
26. REGISTRAR'S SIGNATURE Virgil M. Engelbert

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Virgil V. Straus

Licensed Embalmer No. 4074

P. O. Address Winston,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.