

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 4 9 5 4

FILED VS JAN - 4 1960 274

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 424

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Pettis</u>	Length of stay in 1b	a. STATE <u>Mo</u>	b. COUNTY <u>Pettis</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>	<u>31 yrs</u>	c. CITY OR TOWN <u>Sedalia</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 <u>Bothwell Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>313 West 7th</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<u>MARGARET D. GOLDER</u>			<u>Dec</u>	<u>27</u>	<u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1889</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>nurse</u>	11. BIRTHPLACE (City and state or country) <u>Springfork Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	

13a. FATHER'S NAME <u>Patrick Donahoe</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann Shea</u>	14. NAME OF HUSBAND OR WIFE <u>Howard Golder</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>497-34-3069</u>	17. INFORMANT <u>Jennings Donahoe Greenridge</u> Address <u>R.F.D. #2</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>
IMMEDIATE CAUSE (a)	<u>Acute Cholangiolytic Hepatitis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertension, Essential, Severe</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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 10-5-59 to 12-27-59 and last saw her alive on 12-27-59  
Death occurred at 12:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>T.S. Hopkins, M.D.</u>	22b. ADDRESS <u>1609 S. Limit Sedalia, Mo.</u>	22c. DATE SIGNED <u>12-28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>
23d. LOCATION (City, town, or county) <u>Sedalia</u>	23e. STATE <u>Mo</u>	

24. FUNERAL DIRECTOR <u>Mr. Laughlin Bros</u>	ADDRESS <u>Sedalia</u>	25. DATE RECD. BY LOCAL REG. <u>12-28-59</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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 me

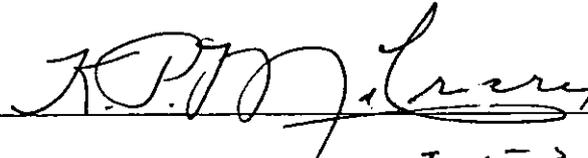
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 315-3

P. O. Address Sedalia

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.