

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JAN 19 1960

=60-002328

Registration District No. 172 Primary Registration District No. 4272 Registrar's No. 6 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waverly</u>		Length of stay in 1b <u>8 weeks</u>	c. CITY OR TOWN <u>Carrollton</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>Kelling Clinic</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>506 W. First</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>MAY</u> Last <u>GODWIN</u>	4. DATE OF DEATH Month <u>Jan.</u> Day <u>12,</u> Year <u>1960</u>
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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>3/7/1864</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Columbus, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Sawin</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Berry</u>	14. NAME OF HUSBAND OR WIFE <u>S. Godwin</u>
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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>none</u>	17. INFORMANT <u>Mrs. Frank Benson, Carrollton, Mo.</u> Address
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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>Cardio Vascular Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mon. plus</u>
DUE TO (b) <u>Arteriosclerosis generalized</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>Fracture of right hip</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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 <u>Waverly, Missouri</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>Nov 16, 1959</u> to <u>Jan 12, 1960</u> and last saw her/him alive on <u>Jan 12, 1960</u> Death occurred at _____ on <u>3:15 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Jordan Kelling MD</u> (Degree or title)	22b. ADDRESS <u>Waverly, Missouri</u>	22c. DATE SIGNED <u>1/14/60</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/14/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>	23d. LOCATION (City, town, or county) <u>Carrollton Mo.</u>
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24. FUNERAL DIRECTOR <u>Gibson Funeral Home</u> ADDRESS <u>Carrollton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-14-1960</u>	26. REGISTRAR'S SIGNATURE <u>Lutie Gordon Jordan</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

03317

(JUN 7 1960

STATEMENT BY LICENSED EMBALMER

JAN 27

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 Ben W Gibson

Licensed Embalmer No. 2961
P. O. Address Carrollton

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.