

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006048

FILED VS MAR 1 1960

139

7

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY HOLT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOLT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Oregon Rural LEWIS TWP	Length of stay in 1b 1 Year	c. CITY OR TOWN FOREST CITY	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) ANNA	First	Middle BELLE	Last GOODWIN	4. DATE OF DEATH Month February Day 17 , Year 1960
--	-------	------------------------	------------------------	--

5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/25/1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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) Arkansas???	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	-----------------------------------	--	--

13a. FATHER'S NAME ? Williams	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE James Goodwin
---	---	---

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. none	17. INFORMANT Address Holt County Welfare Office, Mound City, Mo
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH HAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovasc. Accident		INTERVAL BETWEEN ONSET AND DEATH 2 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Hypertension	unknown
	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. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ 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	COUNTY	STATE
--	--	------------------------------	--------	-------

21. I attended the deceased from **Feb 1, 1960** to **Feb 17, 1960** and last saw her alive on **Feb 17, 1960**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. F. Sullivan M.D.	(Degree or title)	22b. ADDRESS Oregon, Missouri	22c. DATE SIGNED 2/17/60
--	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/20/60	23c. NAME OF CEMETERY OR CREMATORY Forest City Cemetery	23d. LOCATION (City, town, or county) (State) Forest City, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR James H. Pettigrove	ADDRESS Oregon, Mo.	25. DATE RECD. BY LOCAL REG. 2/23/60	26. REGISTRAR'S SIGNATURE James H. Pettigrove
--	-------------------------------	--	---

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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James H. Pettigrew

Licensed Embalmer No. 3192

P. O. Address Oregon

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