

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

**=60-015971**

**FILED VS MAY 9 1960**

*174*

Registration District No. *3035*

Registrar's No. *44*

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington</b>		Length of stay in 1b <b>1 Week</b>		c. CITY OR TOWN <b>Lexington</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lexington Memorial Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>(rural) Lexington Twn'shp</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>MIRIAM</b> Middle <b>BELLE</b> Last <b>GOODLOE</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. September AGE (last birthday) <b>25, 1883</b> <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			11. BIRTHPLACE (City and state or country) <b>Lexington, Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>David L. Mitchell</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Belle Meredith</b>				14. NAME OF HUSBAND OR WIFE <b>Aubry S. Goodloe</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>C. Mitchell Goodloe, Lexington, Mo</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Chronic glomerulonephritis</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>10 days -</b> <b>years -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diastolic Infection</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 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 <b>December 1954</b> to <b>April 21 '60</b> and last saw her him alive on <b>April 20, 1960</b> Death occurred at <b>8:00</b> <b>A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>M.D.</b>						22b. ADDRESS <b>Higginsville, Mo.</b>			22c. DATE SIGNED <b>4/22/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)				
<b>Burial</b>		<b>April 24 '60</b>		<b>Lex. Memory Gardens</b>			<b>Lexington, Mo.</b>				
24. FUNERAL DIRECTOR <b>Crunk-Walker, Lexington, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>4-26-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington

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.