

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

**=60-016141**

**FILED VS MAY 13 1960**

209

Primary Registration District No. 3043

Registrar's No. 177

STATE FILE NUMBER

UNINDEXED

|   |  |  |   |  |   |  |   |
|---|--|--|---|--|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Marion</u>   |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Ralls</u> |   |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>   |  | Length of stay in 1b <u>8 Days</u>   |   | c. CITY OR TOWN <u>Center</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>St. Elizabeth</u>  |  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)  |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| <b>3. NAME OF DECEASED</b> (Type or print) First Middle Last<br><u>Porter Mae Goodman</u>   |  |  |   | <b>4. DATE OF DEATH</b> Month Day Year<br><u>May 4, 1960</u>   |   |  |   |
| <b>5. SEX</b><br><u>Male</u>  | <b>6. COLOR OR RACE</b><br><u>White</u>  | <b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | <b>8. DATE OF BIRTH</b><br><u>July 30-01</u>   | <b>9. AGE</b> (last birthday) <u>59</u>                                   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HR                                      |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>laborer</u>                        |  | <b>11. BIRTHPLACE</b> (City and state or country)<br><u>Pike Co., Mo.</u> |  | <b>12. CITIZEN OF WHAT COUNTRY</b><br><u>U.S.A.</u> |
| <b>13a. FATHER'S NAME</b><br><u>Steven Douglas Goodman</u>  |  |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><u>Nellie Mae Harrilson</u>                   |  | <b>14. NAME OF HUSBAND OR WIFE</b><br><u>Lola G. Goodman</u>              |  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>489-20-1604</u>   |   | <b>17. INFORMANT</b> Address<br><u>Lola G. Goodman, Center, Mo.</u>  |   |  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>generalized peritonitis ruptured appendix</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>about 6 days</u><br><u>about 6 days</u>   |   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)  |   |  |   |  |   |
| <b>20c. TIME OF INJURY</b> Hour a.m. Month, Day, Year   | <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |   |  |   |  |   |
| <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   | <b>20f. CITY, TOWN, OR LOCATION</b>  |  | <b>COUNTY</b>   |  | <b>STATE</b>  |  |   |
| <b>21. I attended the deceased from</b> <u>April 23, 1960</u> to <u>May 4, 1960</u> and last saw her/him alive on <u>5/4/60</u><br>Death occurred <u>9:50 AM PST</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |  |   |  |   |  |   |
| <b>22a. SIGNATURE</b> <u>Loran D. Hurre MD</u> (Deceased or title)  |  |  |   | <b>22b. ADDRESS</b> <u>Vandalia Mo</u>   |   | <b>22c. DATE SIGNED</b> <u>5/5/60</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |  | <b>23b. DATE</b><br><u>May 6, 1960</u>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Vandalia Cemetery</u>             |  | <b>23d. LOCATION (City, town, or county)</b><br><u>Vandalia, Mo.</u>      |  |   |
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><u>Willemin Waters, Vandalia, Mo.</u>  |  |  |   | <b>25. DATE RECD. BY LOCAL REG.</b><br><u>5/9/60</u>   |   | <b>26. REGISTRAR'S SIGNATURE</b><br><u>Dr. E. M. Lucke by Lillian M. Norman</u>  |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 13 1960

**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 William Blaster

Licensed Embalmer No. 4169

P. O. Address Vandalia, Mo

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.