

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038953

FILED VS OCT 17 1960

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 186

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>16 yrs.</u>		c. CITY OR TOWN <u>Chillicothe</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>1401 Bryan St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1401 Bryan St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>GOFF</u> Last <u>GOFF</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</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>8/27/74</u>	9. AGE (last birthday) <u>86</u>	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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (City and state or country) <u>Danville Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Goff</u>			13b. MOTHER'S MAIDEN NAME <u>Eliza Cannon</u>		13c. NAME OF HUSBAND OR WIFE <u>XX</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>491-28-5866</u>		17. INFORMANT <u>Mrs. Verma Reich, Chillicothe, Mo.</u>		
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>Cerebral hemorrhage.</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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>General arteriosclerosis</u>					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 <u>Sept 12</u> to <u>Oct 2</u> and last saw him alive on <u>Sept 30, 1960</u> Death occurred at <u>3 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Dr. M. J. Dawell, M.D.</u> (Degree or title)				22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>10-3-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>Oct. 4, 1960</u>	<u>Wheeling Cemetery</u>		<u>Wheeling Mo</u>			
24. FUNERAL DIRECTOR <u>Donald Gordon, Chillicothe, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Oct 3, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 1961

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 Richard W. Bandal

Licensed Embalmer No. 4860

P. O. Address Chillicothe

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.