

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039461

FILED VS NOV 1 1960

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. - Registrar's No. 419

DED

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township			Length of stay in 1b 18Y; 10M; 9das.		c. CITY OR TOWN Catron		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4,			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS Unknown (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RUSSELL Middle GOODSON Last GOODSON				4. DATE OF DEATH Month October Day 22, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (last birthday) About 80	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			10b. KIND OF BUSINESS OR INDUSTRY Illinois		11. BIRTHPLACE (City and state or country) U.S.A.		
13a. FATHER'S NAME Tom Goodson			13b. MOTHER'S MAIDEN NAME Bettie Keniard			14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records, State Hospital No. 4, Farmington, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis - - - - - as revealed by x-ray 7-21-60.						INTERVAL BETWEEN ONSET AND DEATH revealed	
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) Psychosis with cerebral arteriosclerosis - - Abt. 20 yrs.					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 _____ Month, Day, Year _____ a.m. _____ p.m. _____							
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 Dec. 15, 1941 to Oct. 22, 1960 and last saw ^{him} alive on Oct. 22, 1960 Death occurred at 3:55 a. 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)			22b. ADDRESS State Hospital No. 4 Farmington, Missouri			22c. DATE SIGNED 10-26-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 24, 1960	23c. NAME OF CEMETERY OR CREMATORY Washington Univ. Anat. Dept.		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
24. FUNERAL DIRECTOR Via Miller Funeral Home, Farmington, Mo.			25. DATE RECD. BY LOCAL REG. Oct. 24, 1960		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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bull McKeegal

Licensed Embalmer No. 4120
P. O. Address Farmingdale

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.