

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040725

FILED VS NOV 14 1960

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 261

INDEXED

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|--|--|---|--|---|--|--|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> | | Length of stay in 1b | | c. CITY OR TOWN <u>Sikeston</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>129 North Ingram</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>129 North Ingram</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>----</u> Last <u>Goza</u> | | | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> , Year <u>1960</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov. 16, 1890</u> | | 9. AGE (last birthday) <u>70</u> | | IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u> | | IF UNDER 24 HR Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (City and state or country) <u>Swinton, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>William Goza</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Laura Whipple</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Bertha Goza</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ----- | | | | 16. SOCIAL SECURITY NO. <u>499-01-0143</u> | | 17. INFORMANT Address <u>Bertha Goza, Sikeston, 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>Coronary Thrombosis</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>367 hrs + 04 -</u> | | | |
| 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) | | | | | | | | 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 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 <u></u> a.m. <u></u> p.m. <u></u> | | 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>First Call after Death</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Lydia Rae</u> (Degree or title) | | | | 22b. ADDRESS <u>Carover Sikeston Mo.</u> | | | | 22c. DATE SIGNED <u>10/25/60</u> (State) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>Burial 10/27/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u> | | 23d. LOCATION (City, town, or county) <u>Patton, Mo.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Albritton, Sikeston, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>11-1-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u> | | | | | | | |

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 Raymond L. Duffie

Licensed Embalmer No. 479

P. O. Address Bernie

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