

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-012281

STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 87

FILED APR 16 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0887

2 0890

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9 9570.2

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Moberly</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>Cairo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodland Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>OSWALD</u> Middle <u>LEE</u> Last <u>GOODING</u>			4. DATE OF DEATH <u>March-30-1962</u> Month Day Year
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>8-13-94</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (last birthday) <u>67</u> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Hours Min.
11a. FATHER'S NAME <u>Paul Elmer Gooding</u>		11b. BIRTHPLACE (City and state or country) <u>Cairo Mo U.S.A.</u>	
13a. MOTHER'S MAIDEN NAME <u>Lela Catherine Gooding</u>		14. NAME OF HUSBAND OR WIFE <u>Leta Gooding</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. [redacted]	
17. INFORMANT <u>Mrs. Oswald Gooding</u>		Address <u>Cairo Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Condition undetermined, suspect mesenteric thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u>
DUE TO (b) <u>Fever and leukocytosis, of undetermined origin</u>			<u>5 days.</u>
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>Arteriosclerosis, generalized, severe - 10 years.</u> <u>Paralysis agitans - 5 years.</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>October 1, 1956</u> to <u>March 30, 1962</u> and last saw her/him alive on <u>March 29, 1962</u> Death occurred at <u>3:40 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. C. Cohrs, MD.</u> (Degree or title)		22b. ADDRESS <u>317 Virginia Avenue Moberly, Missouri</u>	22c. DATE SIGNED <u>3/31/62</u>
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE <u>Apr-1-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>S.W. of Cairo Mo.</u>
24. FUNERAL DIRECTOR <u>Cater Funeral Home</u>	ADDRESS <u>Moberly Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-31-62</u>	26. REGISTRAR'S SIGNATURE <u>Teahuboue</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. M. Cater

Licensed Embalmer No. 4117

P. O. Address Moberly 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.