

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031512

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 157

Primary Registration District No. 5582

Registrar's No. 146

FILED AUG 28 1962

VS 300
Rev. 4/59

B 490
3,490

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4 0

5 2

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9 4200

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12 86-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Twp</u>		Length of stay in 1b <u>1 1/2 yrs</u>	c. CITY OR TOWN <u>Sarcoxie</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>Fair Acres</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>-----</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAAC Lawrence GOODSON</u>			4. DATE OF DEATH Month Day Year <u>August 20, 1962</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>4-6-80</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Humansville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>unavailable</u>		13b. MOTHER'S MAIDEN NAME <u>unavailable</u>		14. NAME OF HUSBAND OR WIFE <u>Mary E. Molder Goodson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT Address <u>Neva Wright, Rt 1, Carthage, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					<u>1 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO (c)					<u>10 yrs</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. <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>Jan 1962</u> to <u>8-20-62</u> and last saw <input checked="" type="checkbox"/> him alive on <u>8/20/62</u> Death occurred at <u>7:55</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Sarcoxie, Mo.</u>		22c. DATE SIGNED <u>8-21-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8-22-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sarcoxie, Mo.</u>		
24. FUNERAL DIRECTOR <u>KNELL MORTUARY, Carthage, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-21-62</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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 Frank W. Kell

Licensed Embalmer No. 4440

P. O. Address Carthage, 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.