

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-042176

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 237

STATE FILE NUMBER

FILED NOV 21 1962

VS 300
Rev. 4/59
10365
28260
3
4 1
5 2
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7 0
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122-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Nebraska</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in lb <u>6 mo.</u>	c. CITY OR TOWN <u>Albion</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>✓</u>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>M.</u> Last <u>GOIN</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/3/1871</u>
9. AGE (last birthday) <u>91</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u>	IF UNDER 24 HR Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home Princeton, Mo.</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>James Sparks</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Nichols</u>		14. NAME OF HUSBAND OR WIFE <u>Allen Goin</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>None</u>	17. INFORMANT Address <u>Mrs. W. W. Shoemaker, Washington, 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 <u>84 hours</u>
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			<u>15 yrs</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)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>11:05 A</u> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Washington, Mo.</u>
21. I attended the deceased from <u>Nov. 15, 1962</u> to <u>Nov. 19, 1962</u> and last saw her alive on <u>Nov. 19, 1962</u>		Death occurred at <u>11:05 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>John B. Ryan MD</u>		22b. ADDRESS <u>Washington, Mo.</u>	22c. DATE SIGNED <u>11-19-62</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>11/23/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Edwards Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Edwards, Nebraska</u>
24. FUNERAL DIRECTOR ADDRESS <u>W. H. Voth</u>		25. DATE RECD. BY LOCAL REG. <u>11/19/62</u>	26. REGISTRAR'S SIGNATURE <u>L. C. Hedmann</u> By <u>F. E. Evers</u> Deputy

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 Lester A. Velt

Licensed Embalmer No. 3254
P. O. Address Washington, Mo.

*Embalmed 11/19/62
By J. G. [unclear]*

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.