

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27178

STATE FILE NUMBER

FILED JUL 16 1957

Registration District No. 336 Primary Registration District No. 6124 Registrar's No. 473

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jacks Fork Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Jacks Fork</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Doris</u> Last <u>Goforth</u>			4. DATE OF DEATH <u>July 2-1957</u> Month <u>July</u> Day <u>2</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Feb 11-1882</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>10</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Douglas Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S</u>
13. FATHER'S NAME <u>Joshua Goforth</u>			14. MOTHER'S MAIDEN NAME <u>Betty Counts</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.		17. INFORMANT <u>Ida Bell Goforth</u> Address <u>Jacks Fork, 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>Cardio-renal syndrome</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs +</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>442.X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 <u>1952</u> to <u>7-2-57</u> and last saw ^{see} him alive on <u>6-22-57</u> Death occurred at <u>4 a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Opferus F. Wilson M.D.</u>				22b. ADDRESS <u>Eminence Mo</u>	
				22c. DATE SIGNED <u>7-9-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-4-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New</u>	
<u>Burial</u>				23d. LOCATION (City, town, or county) (State) <u>Eminence, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mt View Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-15-1957</u>		26. REGISTRAR'S SIGNATURE <u>Maude Green</u>

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Joe R. Lunn*.....

Licensed Embalmer No. *42*

P. O. Address *St. Louis*

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.