LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

...ty Bollinger

...nship Lorance

...ge

Registration District No. 67 File No. 15579

Primary Registration District No. 1702C Registered No. 14

(NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charley Edward Goodson

PERSONAL AND STATISTICAL PARTICULARS

...ale | 4 COLOR OR RACE White | 5 ~~SINGLE~~ ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word) W —

...E OF BIRTH Nov (Month) 10 (Day) 1881 (Year)

...E 38 yrs. 4 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

...CUPATION Trade, profession, or ...ticular kind of work Blacksmithing

General nature of industry ...iness, or establishment in ...ch employed (or employer)

...THPLACE ...y or town, ...e or foreign country) Marquand Mo

10 NAME OF FATHER Joel Goodson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Marquand

12 MAIDEN NAME OF MOTHER Emily Pridy

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Marquand

...HE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. R. Sitze

(Address) Bessville Mo

...iled 5/5 1920 E A Sanders Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 April (Month) 8 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 2, 1920, to April 7, 1920, that I last saw him alive on April 7, 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Epilepsy 1

85

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G M Carr M. D.

April 20, 1920 (Address) Marquand Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Trace Creek

DATE OF BURIAL 4/7 1920

20 UNDERTAKER Haman

ADDRESS Marquand Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

(If death occur hospital or ins give its NAME of street and nu

MISSOURI STATE BOARD OF HEA
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1... (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to ....., 19..

that I last saw h..... alive on ....., 19..

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191..... (Address) .....

State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal or Homic

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds.

In the State ..... yrs. ..... mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

..... 191..

20 UNDERTAKER

ADDRESS