

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

Do not use this space.

1. PLACE OF DEATH

County.....**Jasper**..... Registration District No. **417**
Township..... Primary Registration District No. **3021**
City.....**Webb City**..... (No. **316 N. Hall**)

File No. **28144**
Registered No. **115**
St. _____ Ward)

2. FULL NAME **Fred Goforth**

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
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5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF **Edna Goforth**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 27, 1873**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	56	0	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Farming**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER. **Jerome Goforth**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) **Illinois**

12. MAIDEN NAME OF MOTHER **Mary Kane**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) **Illinois**

14. INFORMANT. **Mrs. Edna Goforth**
(Address) **Webb City, Missouri**

15. FILED **8-21, 1929** **R. M. Stormont**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug. 21, 1929**

17. I HEREBY CERTIFY, That I attended deceased from
Aug. 11, 1929, 19____, to **Aug. 21, 1929**
that I last saw him alive on **Aug. 21, 1929** and that death occurred, on the date stated above, at **3:45 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

2 1/2
11 Mo (duration) yrs. mos. ds.

CONTRIBUTORY Influenza
(SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical history and physical examination**
(Signed) **R. M. Stormont**, M. D.

8-21, 1929 (Address) **Webb City, Mo.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Baxter Springs, Kansas** **8-23- 1929**
DATE OF BURIAL

20. UNDERTAKER **Harvey's Und. Co.** **Baxter Spgs. Kansas**
ADDRESS

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

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25
1929
17
7

1
2

AUG 13 1947