

Registration District No. 201

Primary Registration District No. 5280

Registrar's No. 63

1. PLACE OF DEATH:

(a) County: Clay
(b) City or town: Liberty
(c) Name of hospital or institution: Residence
(d) Length of stay: _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Clay
(c) City or town: Liberty Mo
(d) Street No.: P.R. # 3
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME: James Goodman 355

3. (b) If veteran, name war: _____ 3. (c) Social Security No.: _____

4. Sex: Male 5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Libbie G Goodman
6. (c) Age of husband or wife if alive: 23 years
7. Birth date of deceased: April 13 1858
(Month) (Day) (Year)

8. AGE: Years: 83 Months: 10 Days: 15
If less than one day: _____ hr. _____ min.

9. Birthplace: Franklin Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business: _____

MOTHER FATHER
12. Name: Don't Know
13. Birthplace: _____
14. Maiden name: Don't Know
15. Birthplace: _____

16. (a) Informant: John W. Goodman

(b) Address: Liberty Mo RR # 3

17. (a) Burial (b) Date thereof: Feb 29 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: mt Washington

18. (a) Signature of funeral director: W. Mitchell
(b) Address: 310 N Main St Indianapolis

19. (a) Aug 10 (b) W N Sklar
(Date received at local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 27, year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb 25 1940 to Feb 27 1940; that I last saw him alive on Feb 26 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia Duration: 3 days

Due to _____
Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence: _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 9111
While at work? _____ (Specify type of place) (e) Means of injury: _____

23. Signature: W. Goodman (M. D. or other) _____

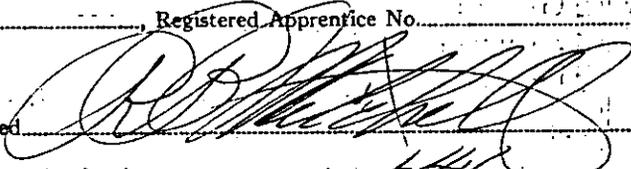
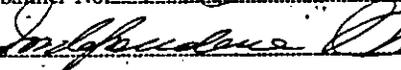
*Address: Liberty Mo Date signed: 7/29/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Filed 8-13-40
District-File Number
District Health Officer No. 8
RECEIVED

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed 
Licensed Embalmer No. 646
P. O. Address 

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 this body is not embalmed, above space should be left blank.