

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.

15 1940

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

24849
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 2 834
 (b) Township Pike Primary Registration District No. 6097
 (c) City Bloomfield Route 1 (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 100 ELIZA K. GOFF
 (a) Residence, No. NO. 100 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF Herbert F. Goff
 (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 16, 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hr. or _____ min.
37 3 8

OCCUPATION
 8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pulaski county Missouri

FATHER
 13. NAME Charles Sheeley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

MOTHER
 15. MAIDEN NAME Emma Akins
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Herbert E. Goff
 (ADDRESS) Bloomfield, Mo. Route 1.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Gravel Hill cem. DATE Aug. 27, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chiles Und. Co. Bloomfield, Missouri

20. FILED Sept 4 8 8 M^c Kee
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 24, 1940

22. I HEREBY CERTIFY, That I attended deceased from MAY 15 1940, to AUG 24 1940
 I last saw her alive on AUG 24 1940 Death is said to have occurred on the date stated above, at 10:55p. m.
 The principal cause of death and related causes of importance were as follows:
CANCER OF THE LIVER Date of onset _____
 Other contributory causes of importance:
CANCER - RIGHT BREAST

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) [Signature]
 (Address) 758 BLOOMFIELD, MO

57

RECEIVED

District Health Officer No. 2,

District File Number 940-1424

Date Filed 9/6/48

SEP 22 1951

NOV 20 1951

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 Luan C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29899

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 834

Primary Registration District No. 6097

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Paris
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Eliza K Gaff

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 37 Months 3 Days 8 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the breast

Primary Secondary

Due to _____

Due to Cancer - rt. breast

Other conditions Cancer of Breast
(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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

1875

1876

1877

1878

1879

1880

1881

1882

1883

1884