

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

1732

State File No. \_\_\_\_\_

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 20

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

1. PLACE OF DEATH

(a) County Jayne

(b) City or town Columbia  
(If outside city or town limits write "RURAL" and name of township)

(c) Name of hospital or institution Wilbur Convalescent Home  
(If not in hospital or institution, write street number or location)

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

In this community Twenty five years

3. (a) PRINT FULL NAME James E Goosetree

3. (b) If veteran, name war v

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie Goosetree alive 80 years

6. (c) Age of husband or wife if 80 years

7. Birth date of deceased 8 5 1857  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>5</u>	<u>19</u>	_____ hr. _____ min.

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

10. Usual occupation Retired farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Goosetree

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

14. Maiden name Don't know

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

16. (a) Informant Minnie Goosetree

(b) Address Columbia, Mo.

17. (a) Burial (b) Date thereof 1-26-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia, Mo Cem

18. (a) Signature of funeral director Parkers (W.N.V)

(b) Address Columbia, Mo

19. (a) 1/27/41 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Columbia, Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 713 Lyons St.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24 -  
year 1941 hour 3 minute 2 M.

21. I hereby certify that I attended the deceased from 1-22-41  
1941 to 1-24- 1941  
that I last saw him alive on 1-23- 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration 3 days

Due to Flu

Due to \_\_\_\_\_

Other conditions Paralysis for the last 4 yrs  
(Include pregnancy within 3 months of death)

Major findings: None

Of operations \_\_\_\_\_

Of autopsy None

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) M

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? No  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No

While at work? No (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature W.D. Lyons (M. D. or other) D

Address Columbia Mo Date signed \_\_\_\_\_

926  
926

8

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 W.H. DauderVenter

Licensed Embalmer No. 2494

P. O. Address Columbia, N.C.

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, fact should be so stated above.

FILE 5774

Registration District No. 73

Primary Registration District No. 3006

Registrar's No.

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbiana  
(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.  
In this community. (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME James E. Gossett  
3. (b) If veteran name war..... 3. (c) Social Security No.....

20. DATE OF DEATH Month Jan day 24  
year 1949 hour..... minute..... M.

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

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.

8. AGE: Years 83 Months 5 Days 19 If less than one day hr..... min.....

Immediate cause of death Pneumo-pneumonia Duration

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

Due to 83d  
Due to.....

10. Usual occupation.....

Other conditions Paralysis for the last four years  
(Include pregnancy within 3 months of death)

11. Industry or business.....

Major findings: Cerebral Hemorrhage  
of operations.....

12. Name.....

Of autopsy..... Underline the cause to which death should be charged statistically.

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.....

(a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4/14/41 (b) Allie Selby (Registrar's signature)

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?  
(Specify type of place) (e) Means of injury.....

23. Signature W. P. Dyar (M. D. or other)  
Address Columbiana Mo Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

W. P. Dyar

S-1732