

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6873

Registration District No. 17 1940 84

Primary Registration District No. 544B

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

**1. PLACE OF DEATH:**

(a) County Dunklin

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community Life  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Dunklin 34

(c) City or town Holcomb  
(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.? 0 years.

**3. (a) PRINT FULL NAME** Nelda Colleen Goldsmith

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 19 1940  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 14 year 1940 hour 7 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 10/12 1940, to 10/14 1940 that I last saw her alive on 10/14/40, 1940; and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
	<u>7</u>	<u>25</u>	hr. _____ min. <u>0</u>

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

Immediate cause of death Bronch pneumonia  
caus.

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**10. Usual occupation** \_\_\_\_\_

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

**MOTHER**

12. Name A. B. Goldsmith

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

14. Maiden name Hester Davis

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

**PHYSICIAN**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**FATHER**

16. (a) Informant's own signature A. B. Goldsmith

(b) Address Holcomb

17. (a) Burial (b) Date thereof Oct-15-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine City

18. (a) Signature of funeral director Louise Swiss

(b) Address Campbell Ave.

19. (a) 3-10-41 (b) J. Anderson  
(Date received local registrar) (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? \_\_\_\_\_

While at work? 250 (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature M. Colleen (M. D. or other) \_\_\_\_\_

Address Holcomb Mo. Date signed 10/14/40

60  
67  
1900  
17  
17

RECEIVED

District Health Officer No. 2

District File Number 341-377

Date Filed 3/13/41

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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.....

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.**