

No. 2
-11-10-39
5-17-39
PI X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11788

State File No. _____

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 67

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

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly Mo
(c) Name of hospital or institution:
Woodland Hospital Moberly Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One Day
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Ruth Ann Goon

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased March 18 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 I hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name John T Goon

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

14. Maiden name Hazel Jarman

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

16. (a) Informant John T Goon

(b) Address R. F. D Higbee Mo

17. (a) Burial (b) Date thereof Mar 20 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roanoke Mo

18. (a) Signature of funeral director Joe W Burton

(b) Address Higbee Mo

19. (a) Mar 20-41 (b) Seal Kellewin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly Mo
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1941 hour 12 minute 35 P.M.

21. I hereby certify that I attended the deceased from March 18 1941 to March 19 1941
that I last saw her alive on March 19 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Intra-cranial hemorrhage
Due to: Cause Unknown

Other conditions: None
(Include pregnancy within 3 months of death)

Major findings: No operation
Of operations: _____
Of autopsy: No Autopsy

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) (a) Means of injury _____

23. Signature [Signature]
Address Higbee Mo Date signed 3-18-41

Duration 4 hrs
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 4-41-791

Date Filed APR 14 1941

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.