

No. 2  
-1-4-4  
5-17-3

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

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

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
821 N. 10th.  
(If not in hospital or institution, write street number or location)

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

In this community 50 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 821 N. 10th.  
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME REV. VINTON M. GOODRICH

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25th.  
year 1941 hour 12 minute 45 AM.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Bessie Goodrich

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased April 18th, 1858  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan - 28 1941 to June 10 1941  
that I last saw him alive on June 10 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>83</u>	<u>2</u>	<u>7</u>	hr. min.
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Immediate cause of death Old Myocarditis.

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

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

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

10. Usual occupation Minister

Other conditions steron ob fracture Jan 28  
(Include pregnancy within 3 months of death)

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

MOTHER FATHER { 12. Name John Goodrich

{ 13. Birthplace Byer Ohio  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Byer Ohio  
(City, town, or county) (State or foreign country)

Major findings: None.

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

Of autopsy none

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Wm. Litz

(b) Address 821 N. 10th. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 6-27-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) June 27, 1941 (b) H. J. Neettlebaum  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_

(e) Means of injury White at work

23. Signature Frank J. Hartigan (M. D. or other) J.M.D.

Address Winepatnot Bldg Date signed 6/25/41

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

**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 me

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

Signed Geo E Daniel

Licensed Embalmer No 3300

P. O. Address St Joseph

**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.**