

No. 2
9-1-41
5-1

FILED MAY 13 1942

State File No. _____

Registration District No. 765

Primary Registration District No. 4-460-266

Registrar's No. 9

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Osceola Rural
(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 21 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair
(c) City or town Osceola Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Americus E. Goode

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Lorena Good

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased 12 (Month)

30 (Day) 1859 (Year)

8. AGE:

Years 82 Months 1 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace

Taylorville (City, town, or county) Ill. (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name Benjamin F. Goode

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

14. Maiden name May Ann Bennett

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

16. (a) Informant Mrs. Luckey

(b) Address Osceola Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-42 (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Mo

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February year 1942 Day 27 hour 11 minute 50 P. M.

21. I hereby certify that I attended the deceased from 1-27 (a.m.) 1942 to 2-27 (p.m.) 1942
that I last saw him alive on 2-27 1942
and that death occurred on the date and hour stated above.

Immediate cause of death

Lobar Pneumonia

Duration

1 week

Due to

Due to

Other conditions (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 T.H. Taylor (M. D. or other) M.D.
Address Osceola, Mo Date signed 3-21-42

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

1102

RECEIVED
District Health Officer No. 7;
District File Number 5-42-446
Date Filed 5-6-42

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 F. B. Goodrich
Licensed Embalmer No. 3038
P. O. Address Oseola 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, fact should be so stated above.

2B
1-41
29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-375-

Registration District No. 765

Primary Registration District No. 6266

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Descola
(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 91 yrs
years, months or days)

3. (a) PRINT FULL NAME Americus E. Goode

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased Dec - 30 - 1875
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 15 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 28-49 Worothy George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Clair

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

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

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 27
year 1942 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of 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)

(e) Means of injury _____

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

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

15375