No. 2
-9-4-41
5-17-39
X29484

FILED JUN 20 1944
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22109

Registration District No. 238 — Primary Registration District No. 4355 — Registrar's No. 17

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town 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 1 (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural 72
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Virginia Sue Goode

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced ✓ 0

6. (b) Name of husband or wife —

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

7. Birth date of deceased 4 (Month) 7 (Day) 1941 (Year)

8. AGE: Years 3 Months 0 Days 24 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Fred Goode
13. Birthplace Charleston (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name Alma McCoy
15. Birthplace Ripley (City, town, or county) Miss (State or foreign country)

16. (a) Informant Fred Goode
(b) Address Kewanee Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-44 (Month) (Day) (Year)
(c) Place: burial or cremation Matthews

18. (a) Signature of funeral director John Albritton
(b) Address Bragaton Mo

19. (a) 5-15-44 (Date received local registrar) (b) Helen Loud Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 1 year 1944 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19.....
that I last saw her alive on 5/1/44, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation

Due to Foreign body

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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) Swallowed foreign body 072
(b) Date of occurrence 5/1/44
(c) Where did injury occur? Kewanee (City or town) New Madrid (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Farm (Specify type of place)
While at work? (e) Means of injury

23. Signature F. J. Allenstein M.D. (M.D. or other)
Address New Madrid Mo Date signed 5/4/44

1818

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 644-882
Date Filed 6-14-44

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

Signed John Allutto

Licensed Embalmer No. 2941

P. O. Address Sikeston Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
1—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registration District No. 238 Primary Registration District No. (4355) Registrar's No. 17

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town 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 years, months or days) Life
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Virginia Sue Goode
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 7 1941 (Month) (Day) (Year)
8. AGE: Years 3 Months 0 Days 24 If less than one day hr. min.
9. Birthplace Mo. (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 5-15-44 (Date received local registrar) (b) Helen Loud Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

22109