

FILED MAY 9 1945
322

Registration District No. _____

Primary Registration District No. 4472

Registrar's No. 3

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

1. PLACE OF DEATH: Saline
(a) County Slater, Mo.
(b) City or town Slater, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
In this community all his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline
(c) City or town Slater
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no
If yes, name country _____

3. (a) PRINT FULL NAME Isaac Warren Goodson
(b) If veteran, name war no
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 7th
year 1945 hour 7 minute P M.

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Alice Goodson
(c) Age of husband or wife if alive 38 years
7. Birth date of deceased: Jan. 26 1904
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-24-37 to 3-7-45
that I last saw ~~her~~ her alive on Mar 7 - 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
41 1 11 hr. _____ min.

Immediate cause of death: Hypostatic Pneumonia
Due to Metrol Stenosis
Heartstenosis
Due to Ch. Parenchymatous Hepatitis
Duration 3 hr
8 yrs.
9 yrs.
3 mo

9. Birthplace Humansville, Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation R.R. Clerk

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

MOTHER FATHER
11. Industry or business _____
12. Name Robert Goodson
13. Birthplace Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Anna Hamlin
15. Birthplace Ohio.
(City, town, or county) (State or foreign country)

Major findings: None
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Robt. Goodson
(b) Address Gilliam, Mo.
17. (a) burial (b) Date thereof 3-9 '45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Slater, MO.
Hill Brothers,
18. (a) Signature of funeral director Slater, Mo.
(b) Address _____
19. (a) _____ (b) Mrs. John Gigu
(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 None
(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 W. E. Leetwood (M. D. or other) MD
Address Slater Mo Date signed 3/10/45

1211

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5/8/45

MAR 4 1946

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 *Sam M Hill*

Licensed Embalmer No. *1292*

P. O. Address *State 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.

DEPART. OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 3

Registration District No. 322 Primary Registration District No. 4472

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Saline
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME Isaac W Goodson
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 Jan 26 1926 (Month) (Day) (Year)

8. AGE: Years 41 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Myocardial Infarction 8 yrs.
Chronic Parenchymatous hepatitis 3 mo.
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration
3 hrs.
8 yrs.
3 mo.
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? _____

23. Signature I. G. Robertson (Specify type of place) _____ (M. D. or other) _____
Address Saline Mo (e) Means of injury _____ Date signed 5/11/55

SUPPLEMENTARY

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

MAR 4 1945

MAY 31 1945

14658