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37357

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 15 1945

Registration District No. Primary Registration District No. 222 Registrar's No. 13

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

1. PLACE OF DEATH:

(a) County Holt

(b) City or town Forest City Mo
(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 Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt 44

(c) City or town Forest City Mo 1
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME James Goodin

3. (b) If veteran, name war _____ **3. (c) Social Security No.** 491 22 6735

4. Sex Male 2 **5. Color or race** Negro

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

6. (b) Name of husband or wife Annabel Goodin **6. (c) Age of husband or wife if alive** 58 years

7. Birth date of deceased August 11 1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>2</u>	<u>4</u>	_____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Dan Goodin

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

14. Maiden name Amanda

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

16. (a) Informant Annabel Goodin

(b) Address Forest City, Missouri

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct. 18 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Forest City, Missouri

18. (a) Signature of funeral director James H. Pettigoh

(b) Address Oregon Mo

19. (a) Date received local registrar Oct 15 45 **(b) Registrar's signature** Gas Chaney

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15
year 1945 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____
Apparently died of
appetitive stroke
Due to diffused cyanosis,
acidosis,

Due to _____

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

Major findings:
Of operations _____ 830
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) _____

(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 Gas Chaney, Chgo Mo (M. D. or other)
Depts. Health Commission
Address _____ Date signed 10-17-45

1454

(Licensed Embalmer's Statement on Reverse Side)

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 James H. Pettigrew

Licensed Embalmer No. 3192

P. O. Address Oregon 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.