

No. 2
M-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

37526

FILED DEC 15 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 157

Primary Registration District No. 5586

Registrar's No. 215

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: County Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months
(Specify whether years, months or days)

In this community 54 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper ⁴⁹

(c) City or town Joplin ²
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no ¹ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William F Goldsmith

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 widowed

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

7. Birth date of deceased May 19, 1883
(Month) (Day) (Year)

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

62	6	9	hr. min.
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9. Birthplace Independence, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name William L Goldsmith

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

14. Maiden name Capitola Hindman

15. Birthplace Couglass Co Kans
(City, town, or county) (State or foreign country)

16. (a) Informant Charles I Goldsmith

(b) Address Coffeyville, Kansas

17. (a) Burial (b) Date thereof 11-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director Parker Hunsaker

(b) Address 1502 Joplin, Joplin, Mo

19. (a) 12-4-45 (b) P. B. Clinton M. O
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 28
year 1945 hour 2 minute 30PM

21. I hereby certify that I attended the deceased from Nov. 23 1945 to Nov. 28 1945
that I last saw him alive on Nov. 28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to Chronic Myocarditis

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 cause, 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 P. B. Clinton (M. D. or other) _____

Address Carthage Date signed Nov 30 1945

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

45-11-934

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. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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.

Registration District No. 157

Primary Registration District No. 5586 5582

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

1. PLACE OF DEATH:

(a) County Jasper, Jackson
 (b) City or town Patton
 (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 _____ years, months or days

3. (a) PRINT FULL NAME William J. Coldsmith
 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 wid
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased May 19 1948
 (Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.
 9. Birthplace _____ (City, town, or county) _____ (State or foreign country) Kansas

MOTHER FATHER

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) _____ (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 1948 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 _____
 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) _____
 (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 _____

SUPPLEMENTARY

37026