

**FILED** APR 15 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 5-609

**1. PLACE OF DEATH:**

(a) County Cape Girardeau  
(b) City or town Jackson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
N 3rd East  
(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 Mable Elise Goehman  
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 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: January 8 1946  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 1 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

**11. Industry or business**

MOTHER FATHER { 12. Name Albert Goehman  
13. Birthplace Cape Gir. Mo.  
(City or county) (State or foreign country)  
14. Maiden name Oma Herzog  
15. Birthplace Allenville MO.  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Goehman  
(b) Address Jackson Mo.

17. (a) Burial (b) Date thereof March 5, 46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Russell Heights

18. (a) Signature of funeral director Wilson Staller Seabaugh  
(b) Address Jackson Mo.  
19. (a) 3-6-46 (b) D. G. Fisher  
(Date received local Registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Cape Gir  
(c) City or town Jackson  
(If outside city or town limits, write "RURAL")  
(d) Street No. N 3rd East  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 3  
year 1946 hour 3 minute 30 M.

21. I hereby certify that I attended the deceased from Jan 9 1946 to March 3 1946  
that I last saw him alive on Feb 17 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Malnutrition abnormal baby had respiratory and heart trouble from birth.  
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 W. G. Fisher (M. D. or other) \_\_\_\_\_  
Address Jackson Mo. Date signed 3-4-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 4  
District File Number 446-2004  
Date Filed 4-13-46

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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.

*Not Embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**