

**FILED JUN 10 1946**

Registration District No. 42

Primary Registration District No. 1000

**1. PLACE OF DEATH:**

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Methodist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Orrin W. Goodman

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Anna Goodman 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased December 10 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 4 28 hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Marcellus Goodman

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

14. Maiden name Johanna Moorman

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

16. (a) Informant Mrs. O. N. Goodman

(b) Address Osborn, Mo.

17. (a) burial (b) Date thereof 5/12/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osborn, Mo.

18. (a) Signature of funeral director Heater Bittel & Bowman

(b) Address St. Joseph, Mo.

19. (a) May 13 1946 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Clinton  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1/2 Mile SE of Osborn, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 9th  
year 1946 hour 2 minute P M.

21. I hereby certify that I attended the deceased from May 7th 1946 to May 9th 1946  
that I last saw him alive on May 9th 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Surgeal shock

Due to Suppuration of Prostate

Due to \_\_\_\_\_

Other conditions Prostate Melancholia  
(Include pregnancy within 3 months of death)

Major findings: Suppuration Prostate  
Of operations \_\_\_\_\_

Of autopsy 61

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 0

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address P. S. 139 St. Joseph Date signed 5/9/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1945

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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.

Signed.....

*Eugene Wood*

Licensed Embalmer No. *3804*

P. O. Address *398 1/2 St Joseph, 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.**