S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 16 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23930

State File No.

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 98

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Jackson Co Emergency Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Das. (Specify whether

In this community 50 yr years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town Indp. Mo. (If outside city or town limits, write "RURAL") 4

(d) Street No. 219 So. Spring (If rural, give location) 4

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME John M. Goodrich

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race Wh

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

6. (b) Name of husband or wife Lillian Goodrich

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

7. Birth date of deceased Dec-30-1878 (Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 7 If less than one day hr. min. 1

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

10. Usual occupation ~~at home~~

11. Industry or business Retired Laundry Driver

FATHER
12. Name Alfred Goodrich
13. Birthplace (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name Anna Morphew
15. Birthplace (City, town, or county) Morphew Indiana (State or foreign country)

16. (a) Informant Mrs M.S. Gibson

(b) Address Netherlands Hotel

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June-19-46 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs C.L. Fowler

(b) Address 918 Brooklyn

19. (a) 6/19/46 (Date received local registrar) (b) Sara G. Barnes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 17 year 1946 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from June 14, 1946 to June 17, 1946 that I last saw him alive on June 16, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	
Due to Arteriosclerosis and hypertension	
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 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. Bohan (M. D. ~~or other~~)

Address 200 Plaza Med Bldg Date signed 6/18/46

135 (Licensed Embalmer's Statement on Reverse Side)

DEC 5 1946

DEC 11 1946

FEB 19 1947

Plaza Med.

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 Cortland Minor

Licensed Embalmer No. 3414

P. O. Address 918 Brooklyn

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.