

FILED MAR 11 1947

Registration District No. _____

Primary Registration District No. 4319

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Belle
(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 entire life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(c) State Missouri (b) County Maries 63
(c) City or town Belle 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27 - 1947
year 8 hour 20 minute P M.

21. I hereby certify that I attended the deceased from Jan 1 1941 to Feb 27 1947
that I last saw her alive on Feb 27 1947
and that death occurred on the date and hour stated above.

Immediate cause of death BRONCHIAL PNEUMONIA Duration 3 days
Due to CHRONIC NEPHRITIS 2 yrs

Due to CHRONIC MYOCARDIAL DEGENERATION -
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy MIB
- 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)
(b) Means of injury _____
23. Signature R.H. Schenck (Registrar)
Address Belle, Mo. Date signed 3/1/47

3. (a) PRINT FULL NAME Susan M. Goodman

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

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

6. (b) Name of husband or wife William P. Goodman 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased: Feb 28 1859
(Month) (Day) (Year)

8. AGE: Years 87 Months 11 Days 27
If less than one day _____ hr. _____ min.

9. Birthplace Maries Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Martin Ridenhour 9

13. Birthplace Unknown 1
(City, town or county) (State or foreign country)

14. Maiden name Sarah Mahon

15. Birthplace Unknown 4
(City, town, or county) (State or foreign country)

16. (a) Informant Rainey Goodman

(b) Address St. John - Mo.

17. (a) Burial (b) Date thereon 3/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty - Belle, Mo.

18. (a) Signature of funeral director Sacrament Funeral Home

(b) Address Belle - Mo.

19. (a) 3-5-47 (b) Pauline Howard
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3-10-47

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 *Chester Sasser*

Licensed Embalmer No. *4178*

P. O. Address *Bland*

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.