

No. 2
-12-45
5-17-39
I 247070

FILED JUN 5 1947

Registration District No. **278**

Primary Registration District No. **3054**

Registrar's No. **47**

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

1. PLACE OF DEATH
(a) County Pike
(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Pike Co Hospital
(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 Julia V. Goveia
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex males 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Martin Goveia 6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased May 12 1858
(Month) (Day) (Year)

8. AGE: Years 88 Months 11 Days 27 If less than one day _____ hr _____ min.

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

10. Usual occupation Housewife

11. Industry or business retired

12. Name Emanuel Vasconcellos
13. Birthplace Madeira Island
(City, town, or county) (State or foreign country)

14. Maiden name Ma Nunies

15. Birthplace Madeira Island
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Harry Smith
(b) Address #2 Louisiana mo

17. (a) Burial (b) Date thereof 5/12/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Ridge Cem Springfield Ill.

18. (a) Signature of funeral director Haley Mortuary

(b) Address Louisiana mo

19. (a) 5/10/47 (b) Bernice Collier
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Pike
(c) City or town Rural Louisiana
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 9
year 1947 hour 4 minute 20 P.M.
21. I hereby certify that I attended the deceased from May 4, 1947 to May 9, 1947
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Acute Congestive Heart Failure</u>	<u>24 hrs</u>
Due to <u>Pulmonary Edema</u>	
<u>Chronic Arterio Sclerosis</u>	<u>18 yrs</u>
Due to <u>Chn. Senile Dementia</u>	<u>5 yrs</u>
Other conditions <u>Comminuted Fracture of Surgical Neck of Left Humerus</u>	
(Include pregnancy within 3 months of death)	

Major findings:
Of operation ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to internal causes, fill in the following:
(c) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
Means of injury _____
2. Signature Robert G. Andrae M.D.
(M. D. or other) _____
Address Louisiana mo Date signed 5/9/47

RECEIVED
District Health Officer No. 10
District File Number 6-47-944
Date filed JUN - 3 1947

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, George O. Wagner,
working under my personal supervision. _____, Registered Apprentice No. _____

Signed

George O. Wagner
Licensed Embalmer No. 3773

P. O. Address Louisiana, 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. *278*

Primary Registration District No. *3054*

1. PLACE OF DEATH:

(a) County *Pike*
(b) City or town *Louisiana*
(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

Julia V. Goveia

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 2*
(Month) (Day) (Year)

8. AGE: Years *88* Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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 *May* year *1947* hour minute M.

21. I hereby certify that I attended the deceased from that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy: *Death not caused by accident*

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) *fracture of*

(b) Date of occurrence *left humerus in a fall*

(c) Where did injury occur? *None* (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

accidental fall occurred at home while entering near door
While at work (specify type of place) (e) Means of injury

23. Signature *Robert L. Audre* (M. D.)

Address *216 Georgia St. Louisiana* Date signed *6/14/47*

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

SUPPLEMENTARY

18372