WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pike

Township ____ or Village ____ or City Bowling Green (NO. ____ St.; ____ Ward)

Registration District No. 684 — File No. 9705

Primary Registration District No. 4408 — Registered No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lillian Jone Gooch

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Feb (Month) 8 (Day), 1915 (Year)

AGE: — yrs. — mos. 28 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ____
(b) General nature of industry, business, or establishment in which employed (or employer) ____

BIRTHPLACE (City or town, State or foreign country): Bowling Green Mo

PARENTS
- NAME OF FATHER: Bert Gooch
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Near McCune Station
- MAIDEN NAME OF MOTHER: Edith Inlow
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Near McCune Staton

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S R Brimer

(ADDRESS) Bowling Green Mo

Filed 3/8, 1915 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mar (Month) 7 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 3, 1915, to Mar 7, 1915, that I last saw her alive on Mar 7, 1915, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas
15B
89A

(Duration) ____ yrs. ____ mos. 5 ds.

Contributory (SECONDARY) Otitis media

(Duration) ____ yrs. ____ mos. 8 ds.

(Signed) T. H. Wilcoxen M. D.

3/8 1915 (Address) Bowling Green Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Mt Pisgah Cemetery — DATE OF BURIAL: Mar 8, 1915

UNDERTAKER: Nattie Elmore — ADDRESS: B Green Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import

...ING INK—THIS IS A PERMANENT RECORD