MARGIN RESERVED FOR BINDING

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

38516

PLACE OF DEATH

County: Jasper

Township or Village or City: Carthage (NO. 824 E 5th St.; Ward)

Registration District No.: 408

Primary Registration District No.: 3020

File No.:

Registered No.: 225

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

FULL NAME: Mary Frances Goodall

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: Dec 10 (Month) (Day), 1850 (Year)

AGE: 67 yrs. 9 mos. 25 ds.

IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House keeper

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

BIRTHPLACE (City or town, State or foreign country): Jersey Ill

PARENTS

NAME OF FATHER: Wm Cox

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

MAIDEN NAME OF MOTHER: Mary Harford

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Wm Goodall

(ADDRESS): Carthage Mo

Filed Nov 13, 1917. C. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov 11 (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 7, 1917, to Nov 10, 1917, that I last saw her alive on Nov 10, 1917, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

10

97

91

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY): Arterial Sclerosis

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) David Wise M. D.

Nov 13, 1917 (Address) 330 Grant St Carthage

*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: St Louis

PLACE OF BURIAL OR REMOVAL: Park Cemetery

DATE OF BURIAL: Nov 14 1917

UNDERTAKER: Knell Uni

ADDRESS: Carthage

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.....

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

..... (Month) ..... (Day), *1* ..... (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

..... (Month) ..... (Day), *191*..... (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