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

Do not use this space.

JAN 19 1928

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No. 36519
Township — Primary Registration District No. 2001 — Registered No. 731
City Springfield Mo (No. 781 W Webster St. Ward)

2. FULL NAME Chas W Goode
(a) Residence. No. 781 W Webster St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Infant
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 18 - 1926
7. AGE: Years 1 — Months 3 — Days 14 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Chas Goode
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky
12. MAIDEN NAME OF MOTHER: Nellie Cullen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

14. INFORMANT: Chas Goode
(Address) 781 W Webster
15. FILED 12/3, 1927 O C Horst Mo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12 - 2 - 1927
17. I HEREBY CERTIFY, That I attended deceased from 11 - 29 - 1927, to 12 - 1 - 1927, that I last saw him alive on 12 - 1 - 1927, and that death occurred, on the date stated above, at 3 P m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
10 M (duration) — yrs. — mos. 3 ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W Kelly M. D
, 19 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Green Lawn Cem — DATE OF BURIAL: Dec 3 1927
20. UNDERTAKER: H H Lohmeyer — ADDRESS: Springfield Mo

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.

[illegible] INK—THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 731
City Springfield (No. ..., ... St. ... Ward)

2. FULL NAME Chas W Goode
(a) Residence. No. ... St., ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 12/3, 1927 O.C. Horst M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 - 2 19 27

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
Primary
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY)
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every ... of ... CAUSE OF DEATH in ...

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW