FEB 22 1929

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

Do not use this space.

Dr. 2462 Twin Springs Mo.

1. PLACE OF DEATH
County: Johnson
Township: Montserrat
City: " (No. ..., St. ..., Ward)

Registration District No. 431
Primary Registration District No. 6-6-23

File No.
Registered No.

2. FULL NAME: Dorothy Louise Goodwin

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept-10-1928

7. AGE: Years —; Months 3; Days 28; If LESS than 1 day, ... hrs. or ... min.

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

9. BIRTHPLACE (CITY OR TOWN): Montserrat
(STATE OR COUNTRY): Johnson Co. Mo.

PARENTS

10. NAME OF FATHER: Jodie Goodwin

11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Johnson Co. Mo.

12. MAIDEN NAME OF MOTHER: Olivia Caldwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Kansas

14. INFORMANT: Jodie Goodwin
(Address): Montserrat Mo.

15. FILED: Jan 14 1929 Wm P Tallesson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1-8- 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929, to Jan 8, 1929, that I last saw h. alive on Jan 8, 1929, and that death occurred, on the date stated above, at 1 — P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(1) accidental suffocation (from cover laying in bed)

180 (Duration) yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) 180 (Duration) — yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? — 34

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Kroboro A. Fenlanger

(Signed) [illegible], M. D.

, 19 (Address) Knob Noster 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: Knobnoster Mo — DATE OF BURIAL: 1-9- 1929

20. UNDERTAKER: Surrey-Fox — ADDRESS: Warrensburg Mo.