

WHITE PAPER, 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**

Do not use this space.

**5425**

27 1930

**1. PLACE OF DEATH**

County Jasper  
Township Webb City Mo  
City Webb City Mo (No. ....)

Registration District No. 417  
Primary Registration District No. 3021

File No. ....  
Registered No. 16  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. J. B. Goff St. .... Ward. ....  
(Usual place of abode) 412 S. Oakland (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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 29, 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>73</u>	<u>10</u>	<u>10</u>	<u>10</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Retired

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

(c) Name of employer .....

**9. BIRTHPLACE (CITY OR TOWN)**

Hazenville Kentucky  
(STATE OR COUNTRY)

**10. NAME OF FATHER**

William Goff

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

Don't Know  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

Alice Bain

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

Don't Know  
(STATE OR COUNTRY)

**14.**

INFORMANT Mrs Luella Goff  
(Address) 412 S. Oakland, Webb City Mo

**15.**

FILED 2-11, 1930 R. M. Stormont  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Jan 1, 1930, that I last saw h. alive on Jan 1, 1930, and that death occurred, on the date stated above, at Feb 9 - 3:30 PM.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary Tuberculosis

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

Home  
IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF No

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. W. Baran, M. D.  
. 1930 (Address) Joplin 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**

Mt. Hope DATE OF BURIAL Feb. 11 1930

**20. UNDERTAKER**

Steele Und. Co ADDRESS Webb City Mo

26 2 31

Dr. Brown

202. Sergeant