

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

Do not use this space.

6686

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**  
(No. of City Hospital #1)

File No.....  
Registered No. **1509**  
St..... Ward.....

**2. FULL NAME**

(a) Residence. No. **204 Allen** St., **23** 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 **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 **Unknown**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **8-9-1906**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**23 6 1**

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. **Chauffeur**  
(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**

10. NAME OF FATHER **Benj Godier**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Mo**

12. MAIDEN NAME OF MOTHER **Minnie Mathem**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Mo**

14. INFORMANT (Address) **Mrs Minnie Godier 24 Allen**

15. FILED **Max C Stanley** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 10, 1930**

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 **4:10 P** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Shock & Burns (1st & 2nd degree burns) 181 m. a case of cause of death could not be ascertained**  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **(No burning Blag)**  
(duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) **John P. Curley** M.D.

\*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.  
**1/7, 1930 (Address) Deputy Pooned**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Carolevy** DATE OF BURIAL **Feb 13 1930**

20. UNDERTAKER **John B Collins** ADDRESS **428 N 9th St**

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.

