

SEP 24 1930

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

Do not use this space.

26304

1. PLACE OF DEATH *Keokuk*
County *Keokuk* Registration District No. *282*
Township *Campbell* Primary Registration District No. *4166*
City *Campbell* (No. _____) St. _____ Ward _____

2. FULL NAME *Matilda J. Goodnight*
(a) Residence. No. *East Mich. 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 *Female*
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 *W. J. Goodnight*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 17 1875*

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	<i>54</i>	<i>10</i>	<i>25</i>	

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

10. NAME OF FATHER *John W. Kenderdine*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *M. J. Goodnight*
(Address) _____

15. FILED *8/12*, 1930 *E. W. Sanders*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 10* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 10* 19 *30*, to *Aug 11* 19 *30* that I last saw her alive on *Aug 11*, 19 *30*, and that death occurred, on the date stated above, at *2:30 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dilatation of the Heart
250 (duration) yrs. mos. *2* ds.
CONTRIBUTORY (SECONDARY) *Deschers' Mellitus*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) *M. L. Cone*, M. D.
, 19 (Address) *Campbell 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 *Woodlawn Cem* DATE OF BURIAL *8/13* 19 *30*

20. UNDERTAKER *E. W. Sanders* ADDRESS *Campbell*

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.

