

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

Do not use this space.

1. PLACE OF DEATH

County Washington Co.

Registration District No. 885-

Township Caledonia, Mo

Primary Registration District No. 45-39

City Caledonia, Mo (No. _____)

28954
File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Thomas Watts Goodykoontz

(a) Residence. No. 10 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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

Mary Knox Goodykoontz

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

Feb 14 - 1879

7. AGE

YEARS <u>81</u>	MONTHS <u>6</u>	DAYS <u>6</u>	If LESS than 1 day, _____ hrs. or _____ min.
--------------------	--------------------	------------------	--

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(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)

Caledonia Mo

PARENTS

10. NAME OF FATHER

George Goodykoontz

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

Virginia

12. MAIDEN NAME OF MOTHER

Harsh Williamson

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

Virginia

14. INFORMANT (Address)

Mrs Mary Goodykoontz
Caledonia, Mo

15. FILED

8-30-1930 Mrs J. M. Knox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 20 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to Aug 20, 1930, that I last saw him alive on June 1, 1930, and that death occurred, on the date stated above, at 4:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

118C
Acute Gastritis
_____ (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Unknown
_____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. Houston, M. D.

, 19 (Address) Belgrade,

*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

Caledonia

DATE OF BURIAL

8-22-1930

20. UNDERTAKER

Herman White & Son Fronton

ADDRESS

Fronton

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

110 1930

947

2
1941

ad
1941

1941
1941

1941

1941

**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 Washington Registration District No. 883- File No. _____
 Township _____ Primary Registration District No. 4536 Registered No. 11
 City Daletonia (No. _____) St. _____ Ward _____

2. FULL NAME Thomas Walter Goody Koontz
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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) _____

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 Oct 9 1930 Mrs. J. M. Knox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute gastritis
caused from eating Fried Egg (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY about 1 hr before death (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

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

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

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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important and should be properly classified. Examination of OCCUPATION is very important.

h5b8e-5