

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

Do not use this space.

DEC 22 1930

File No. **36585**
Registered No. **186**
St. _____ Ward)

1. PLACE OF DEATH

County **Lasper**
Township **Appleton**
City _____

Registration District No. **417**
Primary Registration District No. **55612**

2. FULL NAME

William Frederick Goodwin
(a) Residence. No. **R. Webb City Mo.** St. _____ Ward. _____

(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 Alpha Goodwin

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

May 22, 1890

7. AGE

YEARS **40** MONTHS **6** DAYS **14**
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) **Oklahoma**

10. NAME OF FATHER

William Goodwin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Indiana**

12. MAIDEN NAME OF MOTHER

Ida Mays

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Kentucky**

14. INFORMANT

Mrs Nettie Starchman

(Address) **Carl Junction Mo**

15. FILED

Nov 7, 1930 R. M. Stormont

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov. 6 1930

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930 to July 1, 1930 that I last saw him alive on April 4, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pulmonary T.B. & Tuberculosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Working in Mines
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Chemical

(Signed) **Ed. Humboldt**, M. D.

11/5 1930 (Address) Webb City 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

Messer Maus **Nov. 6 1930**

20. UNDERTAKER

Steele Und. Co. Webb City Mo.

R. 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.

RECEIVED BY THE DIRECTOR OF THE FBI
ON 10/10/50

TO : SAC, NEW YORK
FROM : SAC, PHOENIX
SUBJECT: [Illegible]

10/10/50

RE: [Illegible] (S)

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]