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

Do not use this space.

28803

1. PLACE OF DEATH
County Madison Registration District No. 638
Township Twelve Mile Primary Registration District No. 3726
City ..... (No. ....., ... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME Phleman Goff
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

SEP 24 1931

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Sarah Anna Reed Goff

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 1856

7. AGE: Years 74 | Months 8 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(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): Madison Co. Mo.

PARENTS
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

14. INFORMANT (Address): D. B. Wray Saco

15. FILED 31, 1931 C. U. Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug. 1 1931

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1931, to Aug 1, 1931, that I last saw h..... alive on July 31, 1931, and that death occurred, on the date stated above, at 2:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
8 VA
97 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Sclerosis
..... (duration) 5 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C. U. Davis 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: Brewington Cemetery
DATE OF BURIAL: Aug 2 1931

20. UNDERTAKER: Ed. H. Webb
ADDRESS: Fredericktown Mo.

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