LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

JUN 20 1933

1. PLACE OF DEATH
County Boone — Registration District No. 74 — File No. 15723
Township Rocky Fork — Primary Registration District No. 5113 — Registered No. 6
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Green Perry Goff
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 25 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. Minnie Goff
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mar. 20-1860.
7. AGE: Years 73 — Months 1 — Days 20 — 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) Morgan Co. Mo.

PARENTS
10. NAME OF FATHER: Thomas Goff
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER: Lydia Boyd
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Morgan Co. Mo.

14. INFORMANT: Mrs. Minnie Goff. (Address) Hallsville, Mo.
15. FILED 5-14-1933. Mrs F. L. Fawcett, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 10 1933
17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1933, to May 10, 1933, that I last saw him alive on May 7, 1933, and that death occurred, on the date stated above, at 11 a m.
THE CAUSE OF DEATH* WAS AS FOLLOWS: Cirrhosis of the Liver
(duration) ? yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): Myocarditis
(duration) ..... yrs. 4 mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1243
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C. B. Lawrence, M. D.
May 10, 1933 (Address) Hallsville 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: Union Cemetery — DATE OF BURIAL: May 14 1933
20. UNDERTAKER: G. L. Shock — ADDRESS: Hallsville Mo.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. .....Ward)

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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).....

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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

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..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....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).....,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

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

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