

REC'D OCT 27 1938

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

33573  
Do not use this space.

1. PLACE OF DEATH *Wayne*  
 (a) County *Wayne* Registration District No. *892*  
 (b) Township *Black River* Primary Registration District No. *6194*  
 (c) City *Near Tasker, Mo.* (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. ds. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. ds.  
 2. PRINT FULL NAME *Bessie Myrtle Goff* *157*  
 (a) Residence, No. *Tasker Wayne Co Mo* St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *S*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 19 - 1926*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*12 4 20*  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *School girl*  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 9 - 1938*  
 22. I HEREBY CERTIFY, That I attended deceased from *Sept 1 - 1938*, to *Sept 9 1938*  
 I last saw her alive on *Sept 1 - 1938*. Death is said to have occurred on the date stated above, at *7:10 p.m.*  
 The principal cause of death and related causes of importance were as follows:  
*Typhoid fever* Date of onset *Aug 25 - 38*

Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? *Sal. Urinal* Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *No.*  
 If so, specify \_\_\_\_\_  
 (Signed) *Jno F Wagner*, M. D.  
*Greenville, Mo*  
 (Address) \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) *Advance* (STATE OR COUNTRY) *Stoddard Co Mo.*  
 FATHER 13. NAME *Otha Goff*  
 14. BIRTHPLACE (CITY OR TOWN) *Stoddard Co Mo.* (STATE OR COUNTRY)  
 MOTHER 15. MAIDEN NAME *Flora Null*  
 16. BIRTHPLACE (CITY OR TOWN) *Stoddard Co Mo.* (STATE OR COUNTRY)  
 17. INFORMANT *Otha Goff* (ADDRESS) *Tasker, Mo.*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Estes Cem* DATE *Sept 10 38*  
 19. FUNERAL DIRECTOR *Marsh Lumber Co.* (ADDRESS) *Greenville, Mo.*  
 20. FILED *Sept. 10 1938* *Mr. Walter McShee* Local Registrar.

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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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No.....or by....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**