

Exact statement of OCCUPATION is very important.

REC'D MAR 21 1939

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

7376
Do not use this space.

1. PLACE OF DEATH

(a) County Grege Registration District No. 640
(b) Township Jefferson Primary Registration District No. 5849
(c) City Belle (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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

Sterling Monroe Goodman
(a) Residence, No. Belle, Mo. - P. O. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/14 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Susan F. Goodman

22. I HEREBY CERTIFY, That I attended deceased from 11-1-38, 1938, to 2-12, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 13-1862

I last saw him alive on 2-12, 1939. Death is said to have occurred on the date stated above, at 5 a.m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 11 2

Myocarditis
anemia
acute
Date of onset Chr.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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

Other contributory causes of importance:
Diabetes Mellitus
Jaundice
Arteriosclerosis
Chr.
Chr.
Chr.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maies Co Mo

FATHER 13. NAME David Goodman

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

MOTHER 15. MAIDEN NAME Ann Hoops

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs. B. S. Graft Belle R. O.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pelet Knob DATE 2/16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mattson Funeral Home Ann Mo.

20. FILED 2-15 1939 Mrs. Doris Graft Local Registrar

Name of operation Clinical Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? No

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) H. B. Dume in O!, M. D.
(Address) Belle, Mo



Handwritten scribbles and numbers, including '0.71111' and '1440'.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.