

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

10490  
 Do not use this space.

APR 21 1939

1. PLACE OF DEATH

(a) County Christian 2 Registration District No. 184  
 (b) Township Finley 1 Primary Registration District No. 5255 Registered No. 12  
 (c) City \_\_\_\_\_ (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 Joseph Martin Goddard  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode; if no street address, write county or city)

**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 Nannie Goddard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 24 - 1872

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	<u>64</u>	<u>3</u>	<u>27</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 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 \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) farmer 13  
 13. NAME John H. Goddard 5  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn. 1  
 15. MAIDEN NAME Eliza Jones 1  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT Nannie Goddard  
 (ADDRESS) Ozark, Mo. R

18. BURIAL, CREMATION, OR REMOVAL PLACE Glenn cem DATE Feb. 23 - 39

19. FUNERAL DIRECTOR J. W. Maples  
 (ADDRESS) Clever, Mo

20. FILED Feb 25 1939 Loretta Leonard  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 21 - 1939

22. I HEREBY CERTIFY, That I attended deceased from about 1 p.m. 1939, to 3:30 p.m. 1939  
 I last saw him alive on Feb 21 1939 Death is said to have occurred on the date stated above, at 3:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral hemorrhage  
 Date of onset Feb. 21 1939

Other contributory causes of importance: J. W. Maples

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Physic 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) A. B. Hays on J. H. Hays, M. D.  
 (Address) Glenn and Ozark Mo

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.  
 50M-7-20-37 I X12004

RECEIVED

District Health Officer No. 6,

District File Number 6-39-893

Date Filed APR 14 1939

STATEMENT BY LICENSED EMBALMER

I, J. W. Maples, Licensed Embalmer No. 2985

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

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed J. W. Maples

Licensed Embalmer No. 2985

**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.)**

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Christian  
Township Finley  
City (No. \_\_\_\_\_)

Registration District No. 184  
Primary Registration District No. 5255

File No. 10490-39  
Registered No. \_\_\_\_\_  
St. 12 (Ward)

2. FULL NAME

Joseph Martin Goddard

(a) Residence, No. Osark St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 64 3 27

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
13. NAME John H Goddard  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn  
15. MAIDEN NAME Eliza Jones  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED Mar 5 1939 Luetta Leonard Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_  
If so, specify W. B. Wasson & G. H. Wade  
(Signed) Max A. Osark Mo. M. D.  
(Address) \_\_\_\_\_

SUPPLEMENTARY

REGISTRY RE ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF OCCUPATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

S-10490