APR 21 1939

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

12422
Do not use this space.

1. PLACE OF DEATH
(a) County Saline
(b) Township
(c) City Marshall
Registration District No. 796
Primary Registration District No. 3038 Registered No. 46
(d) Street No. Fitzgibbons Hospital 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 Josephine Rose Goth
(a) Residence, No. 372 West Yearby St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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 Clarance W Goth

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 22, 1902

7. AGE: Years 36 | Months 6 | Days 12 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
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) Wisconsin

FATHER
13. NAME Fred Kempfer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

MOTHER
15. MAIDEN NAME Rose Warner
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wisconsin

17. INFORMANT C. W. Goth
(ADDRESS) Marshall, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Verona, Wis. DATE March 7, 19 39

19. FUNERAL DIRECTOR Campbell-Lewis
(ADDRESS) Marshall, Mo.

20. FILED 3-4-, 19 39 Mary Kent
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-25, 1939, to 3-4, 1939
I last saw h. alive on 3-4, 1939. Death is said to have occurred on the date stated above, at 9 00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	6 days
Other contributory causes of importance:	
Pregnancy	8 mos.

Name of operation — Date of —
What test confirmed diagnosis? Clinical 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
(Signed) Robt M Kennedy, M. D.
(Address) Marshall Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X12004

RECEIVED
District Health Officer No. 8
District File Number 4/10/39
Date Filed

STATEMENT BY LICENSED EMBALMER

I, R.W. Campbell, Licensed Embalmer No. 3469

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

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed R.W. Campbell

Licensed Embalmer No. 3469

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.)