

REC'D JUN 15 1939

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

17947
Do not use this space.

1. PLACE OF DEATH
 (a) County Barry Registration District No. 36
 (b) Township Sugar Creek Primary Registration District No. 5052
 (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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME J. Goins
 (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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 30, 1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5-11-

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) Seligman
 (STATE OR COUNTRY) Barry Co. Mo.

FATHER
 13. NAME Bill Wilds Goins
 14. BIRTHPLACE (CITY OR TOWN) Carroll Co
 (STATE OR COUNTRY) Arkansas

MOTHER
 15. MAIDEN NAME Sylvia Lucile Beaver
 16. BIRTHPLACE (CITY OR TOWN) Barry Co.
 (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) B. J. Goins (Father)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Beaver DATE May 31, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Family

20. FILED 5-31-39 Pellie D. Grant
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-30-39, 1939
 22. I HEREBY CERTIFY, That I attended deceased from May 30, 1939, to May 30, 1939
 I last saw him alive on May 30, 1939 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:

Asphyxiated
Stillborn
 Other contributory causes of importance:
Child birth

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 _____
 (Signed) Dr. Char. R. Brown, M. D.
35 (Address) Seligman Mo.

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

K. 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.

RECEIVED

District Health Officer No. 6,

District File Number 6-6-39-1179

Date Filed JUN 7 1939

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 comply with the above constitutes grounds for revocation of license.)

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