

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.

REC'D SEP 21 1939

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

29632

Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 533  
 (b) Township Rudson Primary Registration District No. 3027  
 (c) City Macon (d) Street No. Macon, Mo. Registered No. 74  
 (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 Mary Gooding

(a) Residence, No. Macon, Mo. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jane's Gooding.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mch. 31, 1866.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
73 4 16

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. Housewife.  
 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) Mo.

FATHER 13. NAME Yock Smith.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky.

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Leota Gooding (ADDRESS) Macon, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Miller Cem. DATE 8/19/39

19. FUNERAL DIRECTOR (NAME) Albert Skinner. (ADDRESS) Macon, Mo.

20. FILED 9/8 1939 Leota Gooding Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug-10-1939 to Aug-17-1939

I last saw him alive on Aug-16-1939. Death is said to have occurred on the date stated above, at 2.00pm

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

Intestinal Obstruction Date of onset 8-15-39

Other contributory causes of importance:

Carcinoma of Colon

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? No

If so, specify..... (Signed) A. L. Gooding, M. D.

(Address) Atlanta Mo

RECEIVED

District Health Officer No. 10

District File Number 9-39-1638

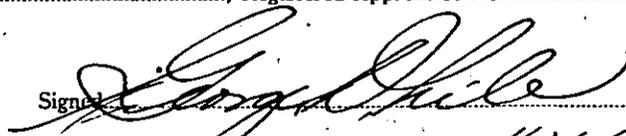
Date Filed SEP 11 1939

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. 4266

P. O. Address Illion, Mo

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.