

REC'D OCT 10 1939

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

32682

Do not use this space.

1. PLACE OF DEATH
(a) County Goplen Registration District No. 41
(b) Township Gatana Primary Registration District No. 2007 Registered No. _____
(c) City Goplen (d) Street No. 1808 Murphy St. _____
(e) Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah M. Locke
(a) Residence, No. 1808 Murphy St. (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) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Edgar
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 13, 1869
7. AGE YEARS 70 MONTHS 3 DAYS 24 If LESS than 1 day, hrs. or min.
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) Kentucky
FATHER 13. NAME George Penn
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
MOTHER 15. MAIDEN NAME Gabriella Skinn
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia
17. INFORMANT (ADDRESS) Mrs. A. W. Lieb Goplen, Mo.
18. BURIAL, CREMATION, OR DISPOSAL PLACE Mt. Hope DATE Sept. 9, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Thurhill Dillon Goplen, Mo.
20. FILED 929 19 39 James Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 7, 1939
22. I HEREBY CERTIFY, That I attended deceased from 7-19, 1938, to 8-14, 1939
I last saw him alive on 8-19, 1939 Death is said to have occurred on the date stated above, at 7 a. m.
The principal cause of death and related causes of importance were as follows:
Toxic Adenoma of Thyroid. Essential Hypertension. Auricular Fibrillation. Date of onset _____
Other contributory causes of importance: W. B.
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? yes
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) W. M. Kinney M. D.
(Address) Goplen, Mo.

RECEIVED

District Health Officer, No. 6,

District number 1039-2089

Date Filed OCT 10 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.....

Don Petriak

Licensed Embalmer No.....

4008

P. O. Address.....

Joplin, 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.