S. No. 2
—11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5925

Registration District No. 85 FILED MAR 11 1940

Primary Registration District No. 1001

Registrar's No. 125

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital / (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community 11 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan

(c) City or town Saint Joseph. (If outside city or town limits write "RURAL")

(d) Street No. 2304 Lovers Lane, (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME 250 Sarah Ellen Goodwin,

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Goodwin, 6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased April 26, 1864 (Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace Marion County, (City, town, or county) Iowa, / (State or foreign country)

10. Usual occupation At Home,

11. Industry or business ____

FATHER
12. Name William Carr, /
13. Birthplace (UNK) (City, town, or county) Iowa, / (State or foreign country)

MOTHER
14. Maiden name Tilytha Fox,
15. Birthplace (UNK) (City, town, or county) Iowa, / (State or foreign country)

16. (a) Informant L. M. Goodwin

(b) Address 2304 Lovers Lane,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation St. Jo. Memorial Park

18. (a) Signature of funeral director Heaton - Bowman Funeral Home

(b) Address 319 S. 10th. Str.

19. (a) Feb 5, 1940 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb'y. day 3rd, year 1940 hour 8: minute 30 p. M.

21. I hereby certify that I attended the deceased from 1 PM. 2-3, 1940, to 8 30 PM. 2-3, 1940 that I last saw her alive on 2-3-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Bronchopneumonia	1 day
Due to Cardiac Decomp.	
Due to Arteriosclerosis Chronic Myocarditis	
Other conditions (Include pregnancy within 3 months of death)	

93 C

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Irwin I Rosenthal M.D. (M. D. or other) /

Address Central Bldg Date signed 2-5-40

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(Licensed Embalmer's Statement on Reverse Side)

23355

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 W. M. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 S. 10th St Joseph

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: