V. S. No. 2
DM—11-10-39
5-17-39
I X21492

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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

FILED MAR 4 1940

State File No. 5982

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 183

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: 2402 S. 3rd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

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

(d) Street No. 2402 S. 3rd.
(If rural, give location)

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

3. (a) PRINT FULL NAME ELIZA GOFF 100

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 Widowed

6. (b) Name of husband or wife David Goff 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. (Month) 9th. (Day) 1863 (Year)

8. AGE: Years 77 Months 0 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Sheraton (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Housewife

11. Industry or business home

FATHER
12. Name Gilbert Percifield
13. Birthplace unknown (City, town, or county) Ky. (State or foreign country)

MOTHER
14. Maiden name Jane Hampton
15. Birthplace unknown (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Sam Scotton
(b) Address St. Joseph, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
WATHENA-KANS
(c) Place: burial or cremation Belmont Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC.
(b) Address 1946 Calhoun St. Joseph, Mo.

19. (a) Feb 16, 1940 (Date received local registrar) (b) H. J. Nesslebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16th
year 1940 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from 2/8, 1940 to 2/12, 1940
that I last saw her alive on 2/12/40, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death General Arterio Sclerosis Hypostatic Pneumonia

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy no

107 W

Duration: Don't know

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)
(e) Means of injury _____

85

23. Signature A. E. Holley (M. D. or other)
Address 822 Edmond St St Joseph Mo Date signed 2/16/40

(Licensed Embalmer's Statement on Reverse Side)

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 C. G. Swan

Licensed Embalmer No. 4082

P. O. Address 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.

V. S. No. 2B
10M—2-21-40
I X22659

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. 5982

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 183

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

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

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

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

3. (a) PRINT FULL NAME Eliza Goff

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4/11/40 (Date received local registrar) (b) H. J. Nestlebach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death General Arterio Sclerosis Hypostatic pneumonia

Due to Bronchial General Arterio Sclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration: Dont know

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

107 W

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 A. E. Holley (M. D. or other)
Address St Joseph Mo Date signed