

Registration District No. **183**

Primary Registration District No. **6-2-6-4**

Registrar's No. **8**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH *Christian*

(a) County *Christian*

(b) City or town *Rural Porter Twp*
(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) *- 2*

(d) Length of stay: In hospital or institution *2*
(Specify whether years, months or days)

In this community *2*
years, months or days

3. (a) PRINT FULL NAME *Elizabeth Gooch*

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 *John C. Gooch*

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

7. Birth date of deceased *Mar. 19-1853*
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<i>86</i>	<i>10</i>	<i>17</i>	hr. _____ min.

9. Birthplace *Howell Co. Mo.*
(City, town, or county) (State or foreign country)

10. Usual occupation *Housewife*

11. Industry or business

MOTHER FATHER

12. Name *Geo. M. Daniel*

13. Birthplace *unknown*
(City, town, or county) (State or foreign country)

14. Maiden name *Susan Sink*

15. Birthplace *unknown*
(City, town, or county) (State or foreign country)

16. (a) Informant *Miss Frank Heilguth*

(b) Address *Nixa, Mo. R-1*

17. (a) *Burial* (b) Date thereof *Feb. 8-1940*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *National Cem. Springfield*
(Specify type of place)

18. (a) Signature of funeral director *L. W. Maples*

(b) Address *Clever Mo. 64109*

19. (a) *Chapman 1/9/40* (b) *Ida D. Hawkins*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Christian*

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

(d) Street No. *Nixa, Mo. R#1*
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb.* day *6th*
year *1940* hour *10* minute *45 P. M.*

21. I hereby certify that I attended the deceased from *Jan. 31*, 19*40* to *Feb. 6*, 19*40*,
that I last saw h. c. u. alive on *Feb. 6*, 19*40*,
and that death occurred on the date and hour stated above.

Immediate cause of death *Broncho-pneumonia complicating a 10 day influenza*

Due to _____

Due to _____

Other conditions *tuberculosis*
(include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations

Of autopsy

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 *X*

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *X*

(e) Means of injury _____

23. Signature *T. B. Newson* (M. D. or other) _____
Address *Nixa Mo.* Date signed *2/17/40*

RECEIVED

District Health Officer No. 6,

District File Number 440-1140

Date Filed APR 15 1940

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 J.W. Maples

Licensed Embalmer No. 2985

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.