

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 821

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: Sikeston

(c) Name of hospital or institution:
415 West Gladys Street 2
(If not in hospital or institution, write street number or location)

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

In this community: _____

3. (a) PRINT FULL NAME: Harry Goodin 350

8. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: male 5. Color or race: colored

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

6. (b) Name of husband or wife: Ethel Goodin

6. (c) Age of husband or wife if alive: 48 years

7. Birth date of deceased: November 16 1896
(Month) (Day) (Year)

8. AGE: Years 48 Months 3 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation: Laborer

11. Industry or business: _____

MOTHER FATHER { 12. Name: Jake Goodin

13. Birthplace: Commerce Missouri
(City, town, or county) (State or foreign country)

14. Maiden name: Allie (unknown)

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

16. (a) Informant's own signature: Ethel Goodin

(b) Address: Sikeston Missouri

17. (a) Burial (b) Date thereof: March 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Sunset Cemetery

18. (a) Signature of funeral director: Harvey Johnson

(b) Address: Sikeston, Missouri

19. (a) 4-5-1940 (b) W. H. Russell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Scott

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

(d) Street No.: 415 West Gladys
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th
year 1940 hour 2 minute 0 A. M.

21. I hereby certify that I attended the deceased from March 2, 1940 to March 5, 1940
that I last saw him alive on March 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: _____ Duration _____

Myocardial infarction
These conditions were
observed in conjunction of the
above mentioned conditions
3) Myocardial infarction

Due to: _____

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

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): no

(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury: _____

23. Signature: W. H. Russell (M. D. or other) _____

Address: Sikeston Date signed: 3/8/40

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WHILE I REMAIN IN USE CONTINUING RECORD
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.

RECEIVED

District Health Officer N

District File Number 440-9

Date Filed 4/8/4

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 Harvey B. Johnson

Licensed Embalmer No. 3704

P. O. Address Sixerton, 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.