

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 836 Primary Registration District No. 4507

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Berlin, Mo.
(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 _____ (Specify whether)
In this community 1 year years, months or days _____

3. (a) PRINT FULL NAME Sallie Goodwin
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Robert L. Goodwin 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased April 4 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Henry Pickett
13. Birthplace Carlisle Co. Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Raney Adair
15. Birthplace Lenox
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert L. Goodwin
(b) Address Berlin Mo

17. (a) Burial (b) Date thereof 2-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Berlin Mo

18. (a) Signature of funeral director Allen Eason
(b) Address Berlin, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Stoddard
(c) City or town Berlin, Mo.
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 14
year 1940 hour 7:15 minute 9 M.

21. I hereby certify that I attended the deceased from Feb. 13th 1940 to Feb. 18th 1940
that I last saw alive on Feb. 15th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration 8 days

Due to Asthma and Influenza

Due to _____

Other conditions 43 H
(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) _____

(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? Y

(e) Means of injury _____
While at work? _____ (Specify type of place)

23. Signature J. P. Carron (M.D. or other) MD

Address Dexter Date signed 2/18/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

RECEIVED

District Health Officer No. _____

District File Number 440-92

Date Filed 4/8/40

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 John J. [Signature]

_____, Registered Apprentice No. _____
working under my personal supervision.

No Embalming done.

Signed [Signature] Edman

Licensed Embalmer No. [Signature]

P. O. Address [Signature]

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.

o. 2B
21-40
V 22-68

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12616
Registrar's No. 24

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 836

Primary Registration District No. 4507

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

1. PLACE OF DEATH:

(a) County Woodward

(b) City or town Berme
(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)

3. (a) PRINT FULL NAME Sallie Goodwin

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

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	Months	Days	If less than one day
	<u>68</u>	<u>10</u>	<u>11</u>	_____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

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

19. (a) May 15 1940 (b) Laura Hopkins (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 14 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 _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature J. T. Cannon (M. D. or other) _____
Address Dexter _____ Date signed _____

SUPPLEMENTAL

1940

S-12616