

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.

MAY 24 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14488

Do not use this space.

1. PLACE OF DEATH

(a) County CALLAWAY Registration District No. 104
(b) Township..... Primary Registration District No. 3008 Registered No. 132
(c) City..... FULTON 3 (d) Street No. Massouy, Hospital St. 1-1
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 6 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

325 WILLIAM R. GOODSON
(a) Residence, No. PERRY Mo. C St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF EMMA GOODSON
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 15, 1886
7. AGE YEARS 54 MONTHS 0 DAYS Y3 If LESS than 1 day, hrs. or min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER
9. Industry or business in which work was done, as saw mill, bank, etc. Farm.
10. Date deceased last worked at this occupation (month and year) 2A 11. Total time (years) spent in this occupation 2A

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DOUGLAS Co., Ill.

FATHER 13. NAME FRANK GOODSON
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILLINOIS

MOTHER 15. MAIDEN NAME SUSAN SMITH
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILLINOIS

17. INFORMANT Hospital Record.
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mexico. Mo. DATE May 10, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Earl E. Pugh
Mexico. Mo.

20. FILED May 8, 1940 R. N. Cross
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAY 8, 1940

22. I HEREBY CERTIFY, That I attended deceased from MAY 2, 1940, to MAY 8, 1940
I last saw him alive on MAY 8, 1940. Death is said to have occurred on the date stated above, at 11:45 a.m.
The principal cause of death and related causes of importance were as follows:

Coronary Sclerosis.

Date of onset

Other contributory causes of importance:

Generalized Arteriosclerosis
Chronic Myocarditis.

Name of operation..... Date of.....
What test confirmed diagnosis? Clinical Was there an autopsy?.....

23. If death was due to external causes, (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....
(Signed) Geo. F. Wray, M. D.
106 (Address) State Hosp. #7, Fulton, Mo.

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..... *Carl E. Pinedo*

Licensed Embalmer No. *3189*

P. O. Address..... *Mexico, Mex*

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.