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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 E. Reininger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18139

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 136

Primary Registration District No. 5220

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Peccoliar T.P.
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Henry M. Goodwin

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

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

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
70 1 21 hr. min.

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

10. Usual occupation

11. Industry or business

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 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (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

20. DATE OF DEATH: Month May day 17
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
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis
Cerebral Hemorrhage
Due to
Due to 87W
Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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) (c) Means of injury
23. Signature T. M. Griffith (M. D. or other)
Address Harrisonville Mo.

SUPPLEMENTAL CERTIFICATE

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

