

Registration District No. 238

Primary Registration District No. 5328

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Golden City, Marion 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

8. (a) PRINT FULL NAME LOMAN ADOLPUS DEGOOD
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
(b) Name of husband or wife Margaret De Good 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 22 - 1851
(Month) (Day) (Year)

8. AGE: Years 88 Months 6 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer and Minister

11. INDUSTRY OR BUSINESS OF FATHER
12. Name Arson De Good
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
(b) Address Living at _____

17. (a) _____ (b) Date thereof March 26, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ives Golden City, Mo.
18. (a) Signature of funeral director G. A. Phillips
(b) Address Golden City, Mo.

19. (a) 3-29-1940 (b) J. A. Wheeler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dade
(c) City or town Golden City Rural
(If outside city or town limit, 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 24 day March
year 1940 hour 3 minute 30 P. M.
21. I hereby certify that I attended the deceased from March 23, 1940 to March 24, 1940
that I last saw him alive on March 24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 days
Due to _____
Due to _____
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?
215 (Specify type of place) _____
While at work? _____ (a) Means of injury _____
23. Signature John Brooks (M. D. or other) _____
Address Golden City, Mo. Date signed 3-27-40

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.

1935

1092

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..... *W. G. Pugh*.....
Licensed Embalmer No. *3278*
P. O. Address *Golden City, 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. 31855-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 238

Primary Registration District No. 2328

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Marion T.P.
(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

Loman Adolphus De Good

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 wid
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 38 Months 16 Days 24 If less than one day _____ 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) _____ (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 Mar day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Bronchial Pneumonia

Due to _____

Due to _____

Other conditions. (Include pregnancy within 3 months of death) 107W

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) (e) Means of injury _____

23. Signature J.M. Brantley M.D. (M. D. or other)

Address Chillicothe City Mo Date signed 10-18-40

SUPPLEMENTARY

Duration 2 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

