

Registration District No. 2420

Primary Registration District No. 5E33

Registrar's No. 116

1. PLACE OF DEATH:  
 (a) County Lawrence  
 (b) City or town Mr Vernon mo  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: X  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 20  
(Specify whether)  
 In this community all his life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Lawrence  
 (c) City or town Mr Vernon mo  
(If outside city or town limits, write "RURAL")  
 (d) Street No. X  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME John William Gooding  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept day 20  
 year 1940 hour about 3 minute 30 P. M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife manie 6. (c) Age of husband or wife if alive 30 years  
 7. Birth date of deceased July 13 1900  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from after death, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>6</u>	<u>7</u>	hr. _____ min. _____

Immediate cause of death probable Angina Pectoris  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions 94W  
(Include pregnancy within 3 months of death)

10. Usual occupation Day-Laborer & Farmer

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy no

MOTHER FATHER  
 12. Name William Felix Gooding  
 13. Birthplace Lawrence Co mo  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

14. Maiden name Mary Elizabeth Jefford  
 15. Birthplace Mr Vernon mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Bevel Gooding  
 (b) Address Mr Vernon mo  
 17. (a) Burial (b) Date thereof Sept 23 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) X  
 (b) Date of occurrence X  
 (c) Where did injury occur? X  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
421 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

(c) Place: burial or cremation Funeral  
 18. (a) Signature of funeral director Geo B Orr  
 (b) Address Mr Vernon mo  
 19. (a) Sept 20, 1940 (b) P. A. HOLMES  
(Date received local registrar) (Registrar's signature)

23. Signature Herman Burridge (M. D. or other) 5  
 Address Aurora mo Date signed 9/20/40

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

RECEIVED

District Health Officer No. 6,

District File Number: 1040-2-761

Date Filed OCT 17 1961

**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

*Geo B Olin*

Licensed Embalmer No.

946

P. O. Address

*7th Yarrow*

**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, fact should be so stated above.**