S.
I—9-4-41
. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 11 1940

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3002

36549

State File No.

Registrar's No. 166

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Audrain County Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone 10
(c) City or town Centralia 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Luther Goslin
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 Married
6. (b) Name of husband or wife Inel Goslin
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Jan (Month) 9 (Day) 1859 (Year)

8. AGE: Years 83 Months 10 Days 6 If less than one day hr. min.

9. Birthplace Boone Co (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER
12. Name W. W. Goslin
13. Birthplace (City, town, or county) Ky 1 (State or foreign country)
MOTHER
14. Maiden name Paulina Tucker
15. Birthplace (City, town, or county) Va 1 (State or foreign country)
16. (a) Informant Mrs John Goslin
(b) Address Centralia Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16-1942 (Month) (Day) (Year)
(c) Place: burial or cremation Friendship Church
18. (a) Signature of funeral director M. Mc Donald
(b) Address Centralia Mo
19. (a) 11/16-1942 (Date received local registrar) (b) Margaret H Mackie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 15th year 1942 hour 12 minute 15 A.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.

	Duration
Immediate cause of death Hypostatic Pneumonia	4 Days.
Due to	
Due to	
Other conditions Fracture Femur intertrochanteric (Include pregnancy within 3 months of death)	2 weeks

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) 010
(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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Frank W. Bardenwerper (M. D. or other)
Address Centralia Mo Date signed 11-16-42

1074 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 12-42-40 T6
Date Filed Dec-10-42

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 M J McDonald

Licensed Embalmer No. 4313

P. O. Address Centralia Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 365-49

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 166

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Andrain

(b) City or town Co-Hosp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7 days
(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)

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) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME John Luther Gaslin

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 M

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Jan (Month) 9 (Day) 1859 (Year)

8. AGE: Years 83 Months 10 Days 6 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

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

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15
year 1942 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.

	Duration
Immediate cause of death Hypostatic Pneumonia	4 days
Due to	
Due to	
Other conditions Fracture Femur (Include pregnancy within 3 months of death)	2 mo
Major findings: Of operations 195e'	
Of autopsy 99	

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) accident
(b) Date of occurrence Nov. 1, 1942
(c) Where did injury occur? at Home - (City or town) Centralia (County) MO (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature Frank McBarden, M.D. (M. D. or other)
Address Centralia MO Date signed .....

S-36548 1942